JUNE 2006

A DATA BOOK

Healthcare Spending and the Medicare Program

MEDPAC Medicare Payment Advisory Commission

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Introduction

MedPAC's Data Book is the result of discussions with Congressional staff members regarding ways that MedPAC can better support them. It contains the type of information that MedPAC provides in publications like the March or June reports; it also combines data from other sources, such as CMS. The format is condensed into tables and figures with brief discussion. Web site links to MedPAC publications or other websites are included on a "Web links" page at the end of each section.

The Data Book provides information on national health care and Medicare spending, as well as Medicare beneficiary demographics, dual eligible beneficiaries, quality and access in the Medicare program, and Medicare beneficiary and other payer liability. It also examines provider settings—such as hospitals or post-acute care—and presents data on Medicare spending, percent of beneficiaries using the service, number of providers, volume, length of stay, and margins, if applicable. In addition, it covers the Medicare Advantage program and prescription drug coverage for Medicare beneficiaries, including Part D.

Limited printed copies are being distributed. This report is, however, available through the MedPAC website: www.medpac.gov.

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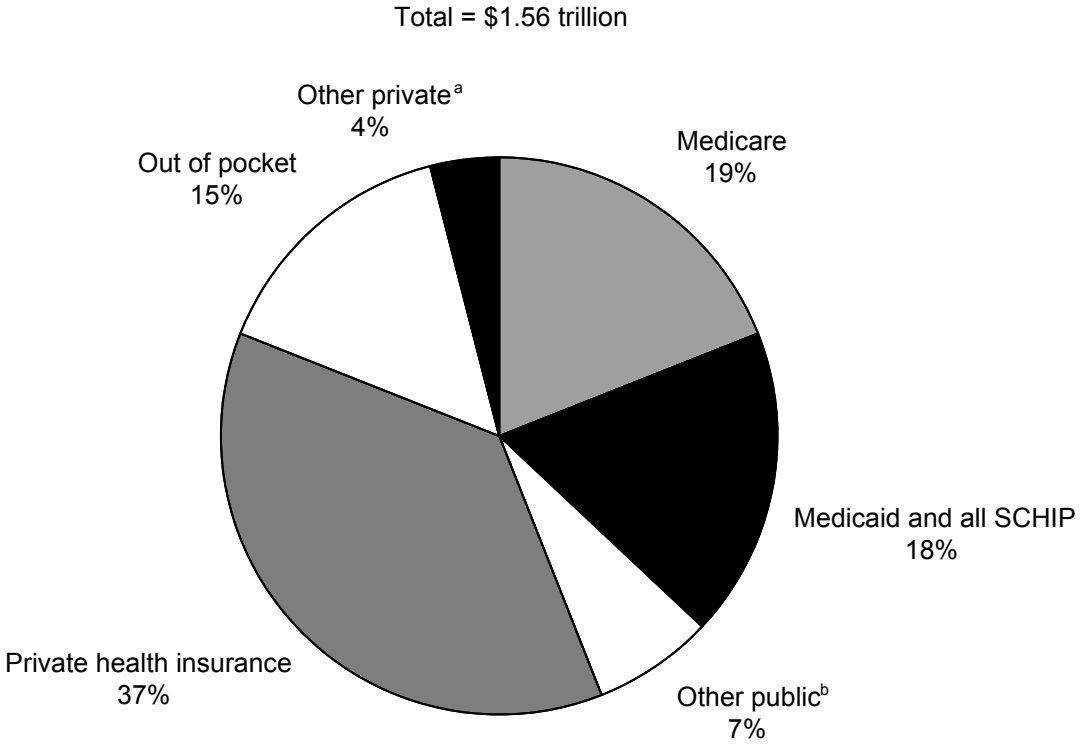
SECTION 1

National health care and Medicare spending

Chart 1-1. Medicare made up about one-fifth of spending on personal health care in 2004



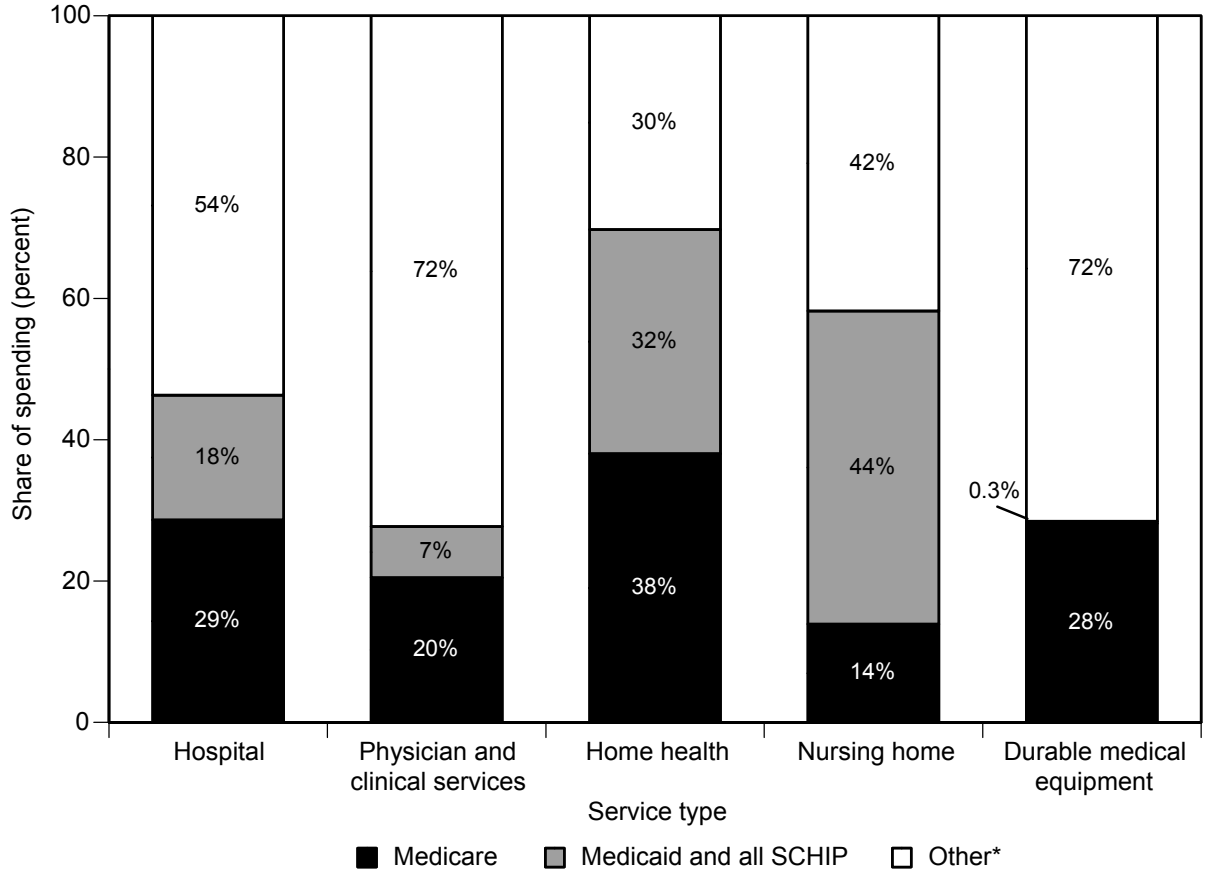
Note: SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance), rather than in the out-of-pocket category.
[a] Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.
[b] Includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, state and local government hospital subsidies, and school health.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

- Of the $1.56 trillion spent on personal health care in the United States in 2004, Medicare accounted for about 19 percent, or $300 billion. Spending by all public programs—including Medicare, Medicaid, State Children's Health Insurance Program, and others—accounted for 44 percent of health care spending. Medicare is the largest single purchaser of health care in the United States. Thirty-seven percent of spending was financed through private health insurance payers (employers and plans) and 15 percent was from consumer out-of-pocket spending.

- Medicare and private health insurance spending includes premium contributions from enrollees.

Chart 1-2. Medicare's share of total spending varies by type of service, 2004



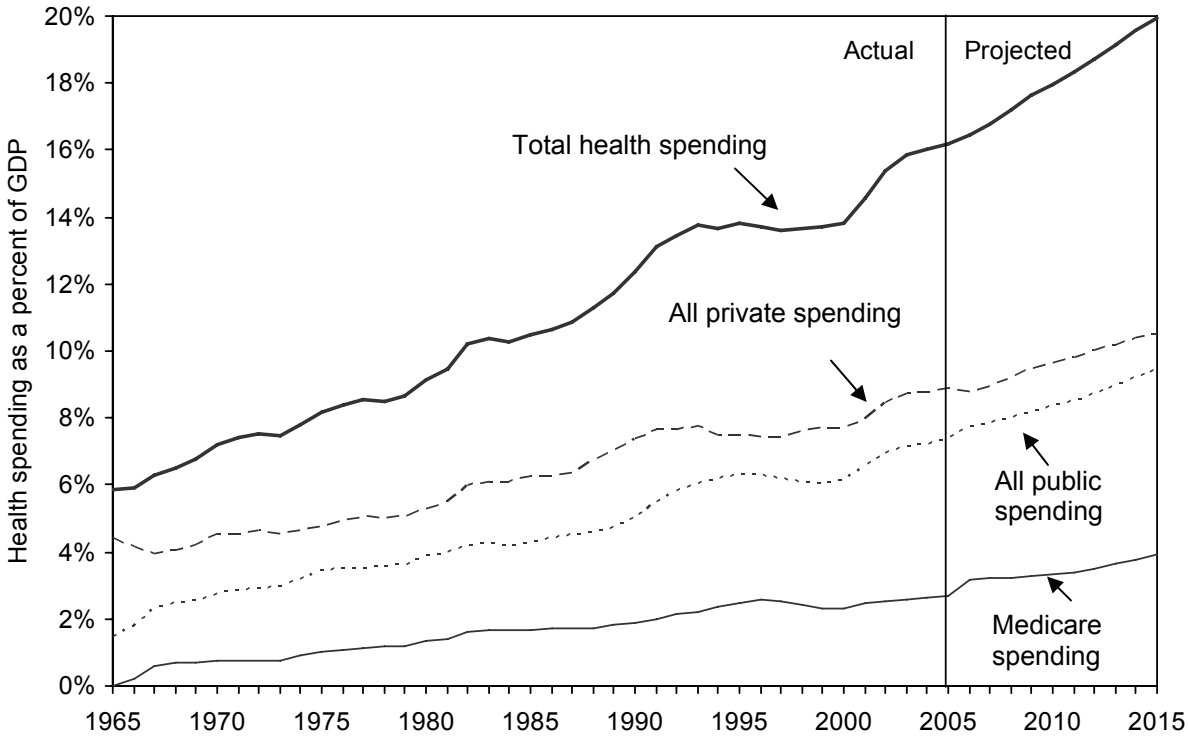
Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits.
Totals may not sum to 100 percent due to rounding.
*Other includes private health insurance, out-of-pocket, and other private and public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population, and did not cover services such as outpatient prescription drugs and long-term care during this time period.

- In 2004, Medicare accounted for 29 percent, 38 percent, and 28 percent of spending on hospital care, home health services, and durable medical equipment, respectively. By comparison, Medicare paid for 14 percent of nursing home care.

Chart 1-3. Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding



Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

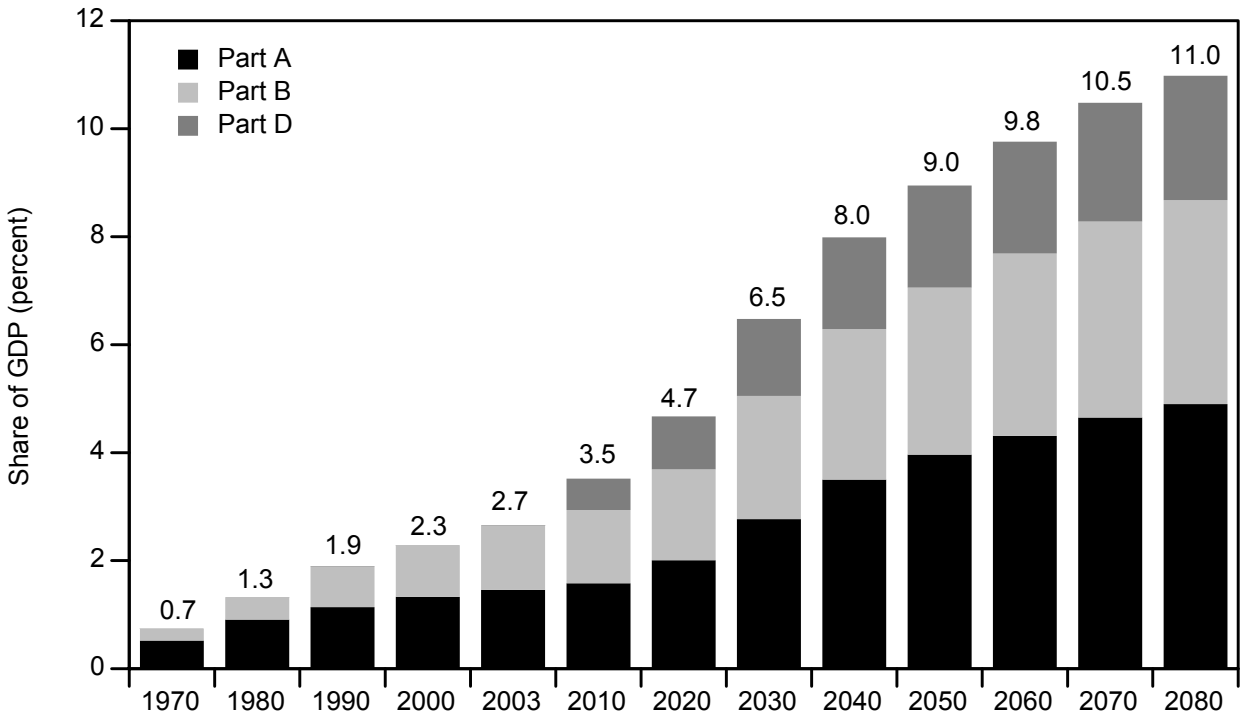
- Total health spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1982.

- As a share of GDP, total health spending has increased from about 6 percent in 1965 to more than 16 percent in 2004. It is projected to reach 20 percent of GDP in 2015. Health spending's share of GDP was stable throughout much of the 1990s due to slower spending growth associated with greater use of managed care techniques and larger enrollment in managed plans as well as a strong economy.

- Medicare spending has also grown as a share of the economy from less than 1 percent when it was started in 1965 to about 3 percent today. Projections suggest that Medicare spending will make up nearly 4 percent of GDP by 2015.

- In 2004, public spending made up about 45 percent of total health care spending and private spending made up 55 percent. By 2015, those percentages are projected to be 48 percent and 52 percent, respectively.

Chart 1-4. Trustees project Medicare spending to increase as a share of GDP



Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

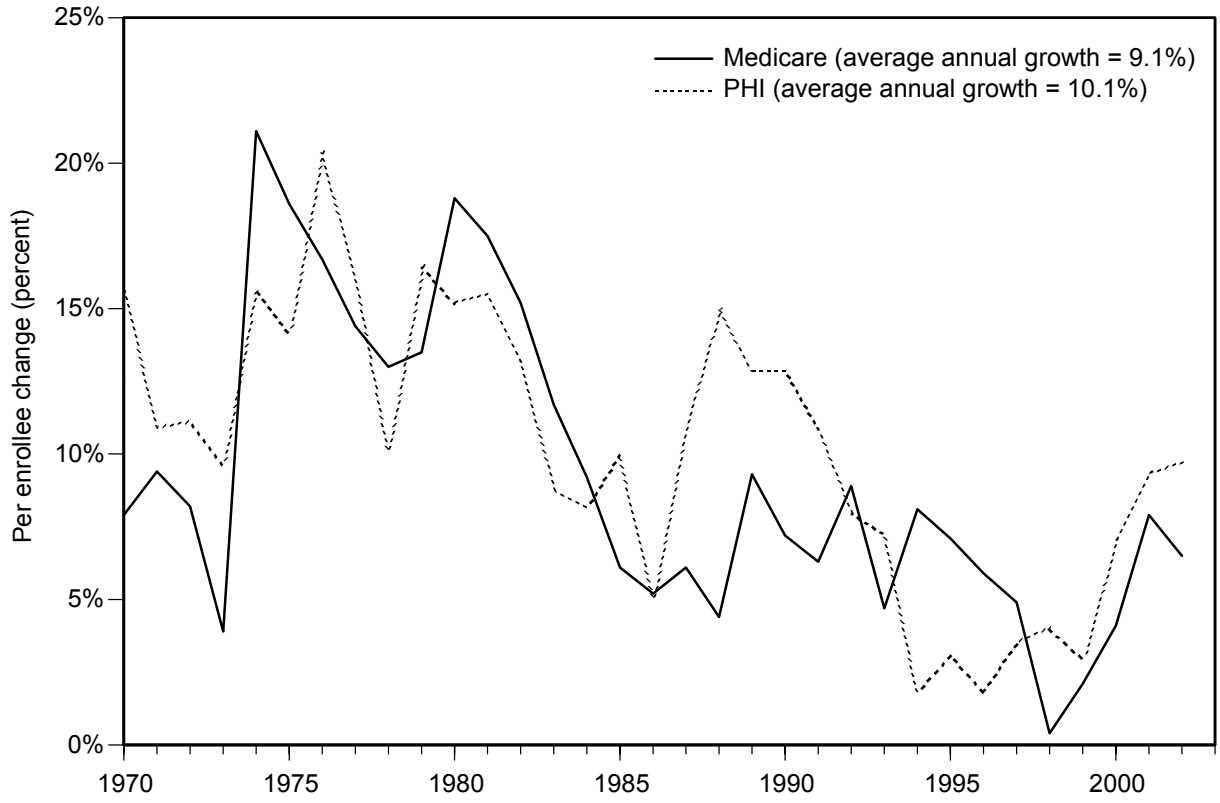
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- Over time, Medicare spending has accounted for an increasing share of gross domestic product (GDP). From less than 1 percent in 1970, it is projected to reach 11 percent of GDP in 2080.

- With a 9.3 percent annual average rate of growth, nominal Medicare spending grew considerably faster over the period from 1980 to 2004 than nominal growth in the economy, which averaged 6.5 percent per year. For the future, Medicare spending is projected to continue growing faster than GDP, but at a rate somewhat closer to GDP growth, averaging 6.2 percent per year between 2004 and 2080 compared with an annual average growth rate of 4.5 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP, but at a slower pace.

- During the 1990s, Medicare's share of the economy grew more slowly than it did in other periods. This was due to payment reductions enacted in 1997, combined with faster economic growth. Beginning in 2010, the aging of the baby boom generation, an expected increase in life expectancy, and the Medicare drug benefit are all likely to increase the proportion of economic resources devoted to Medicare. Additional factors such as innovation in medical technology and interaction between the use of technology and insurance coverage will also contribute to rapid increases in health care spending.

Chart 1-5. Changes in spending per enrollee, Medicare and private health insurance



Note: PHI (private health insurance). Chart compares services covered by Medicare and PHI, including hospital services, physician and clinical services, and durable medical products.

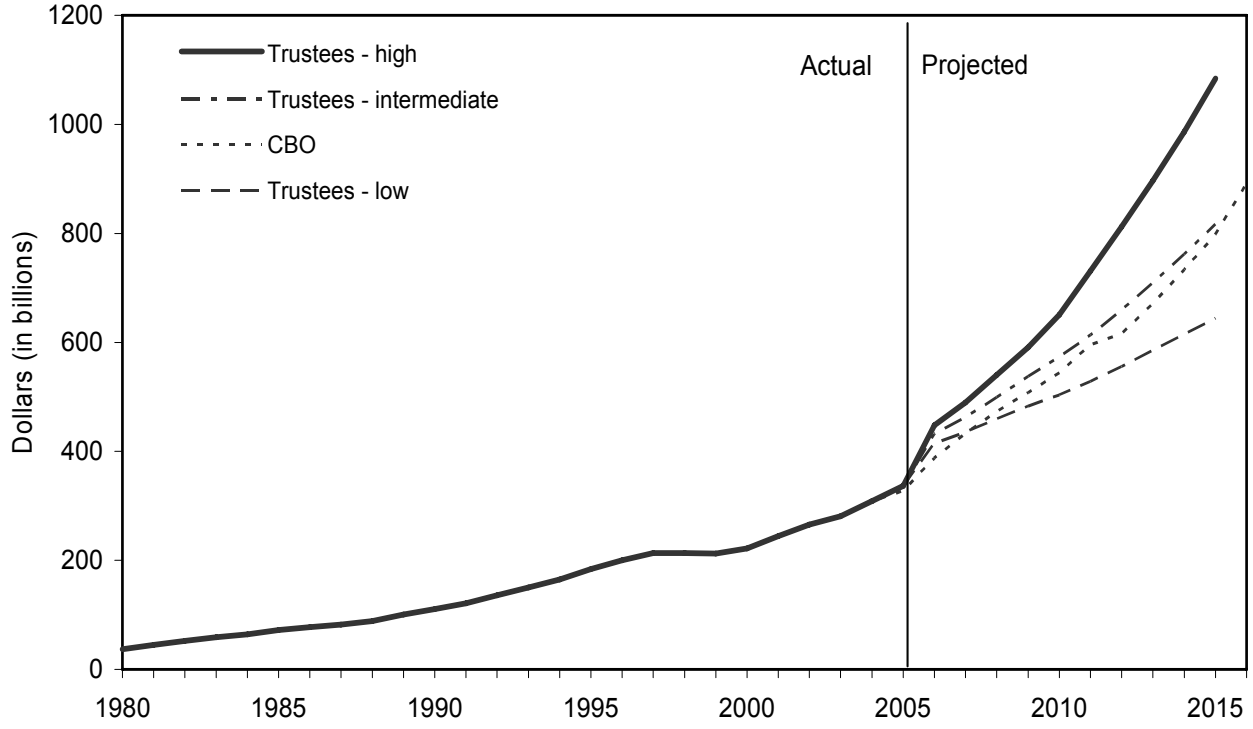
Source: CMS, Office of the Actuary, National Health Statistics Group, 2004.

- Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar. When comparing spending for benefits that private insurance and Medicare have had in common—notably excluding prescription drugs—Medicare's per enrollee spending has grown at a rate that is about 1 percentage point lower than that for private insurance over the period from 1970 to 2002.

- This comparison is sensitive to the end points of time one uses for calculating average growth rates. Also, private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. In addition, the data do not allow analysis of the extent to which these spending trends were affected by changes in the generosity of covered benefits and, in turn, changes in enrollees' out-of-pocket spending.

- Differences appear to be more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services. Some analysts believe that since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power. Others maintain that since the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. In addition, enrollment in managed care plans grew during the 1990s. These factors make the comparison problematic, since Medicare's benefits changed little over the same period.

Chart 1-6. Trustees and CBO project Medicare spending to grow at an annual average rate of 7 percent to 8 percent over the next 10 years

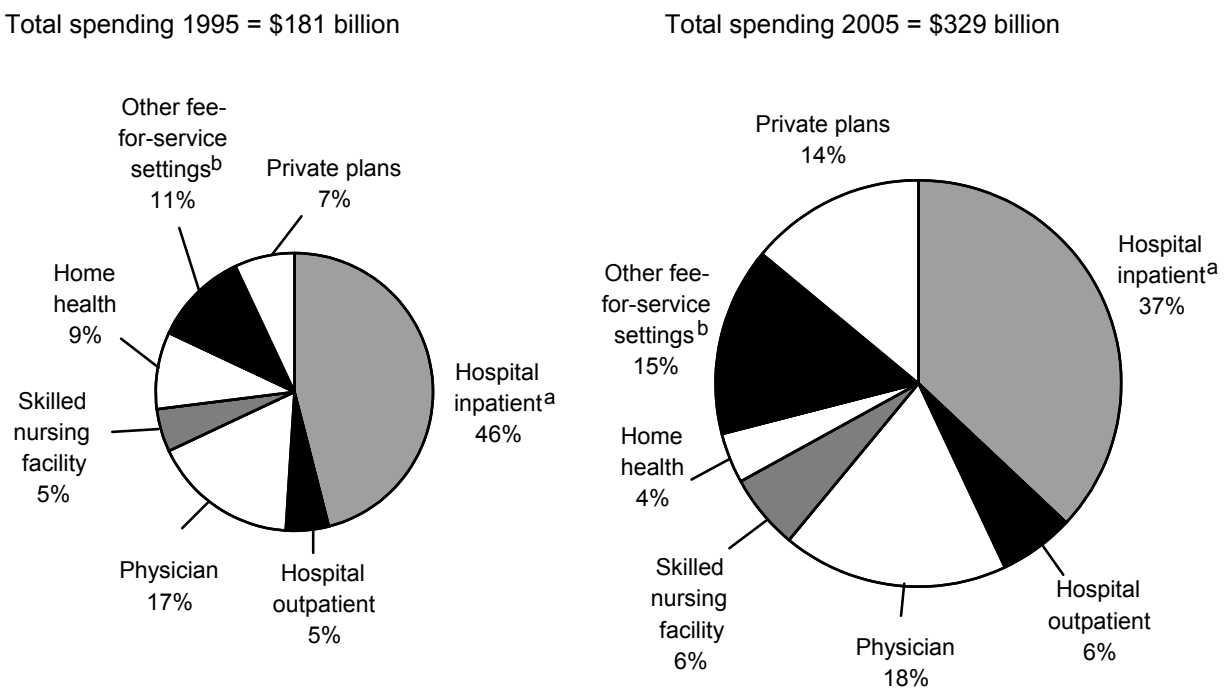


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: Medicare Trustees Report 2006. CBO March 2006 baseline.

- Medicare spending has grown about ninefold, from $37 billion in 1980 to $336 billion in 2005.
- Medicare spending will increase significantly in 2006 and in subsequent years with introduction of Part D, the new voluntary outpatient prescription drug benefit.
- The Congressional Budget Office projects that mandatory spending for Medicare will grow at an average annual rate of about 8 percent from 2006 to 2015. The Medicare Trustees' intermediate projections for 2006 to 2015 assume about 7 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-7. Medicare spending is concentrated in certain services and has shifted over time



Note: Spending amounts are gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or spending on their behalf) for cost sharing requirements of Medicare-covered services. Values are reported on a calendar year, incurred basis and do not include spending on program administration. Totals may not sum to 100 percent due to rounding.
[a] Includes all hospitals—those paid under the prospective payment system (PPS) and PPS-exempt hospitals.
[b] Includes hospice, outpatient laboratory, durable medical equipment, physician-administered drugs, ambulance services, ambulatory surgical centers, dialysis, rural health clinics, federally qualified health centers, and outpatient rehabilitation facilities.

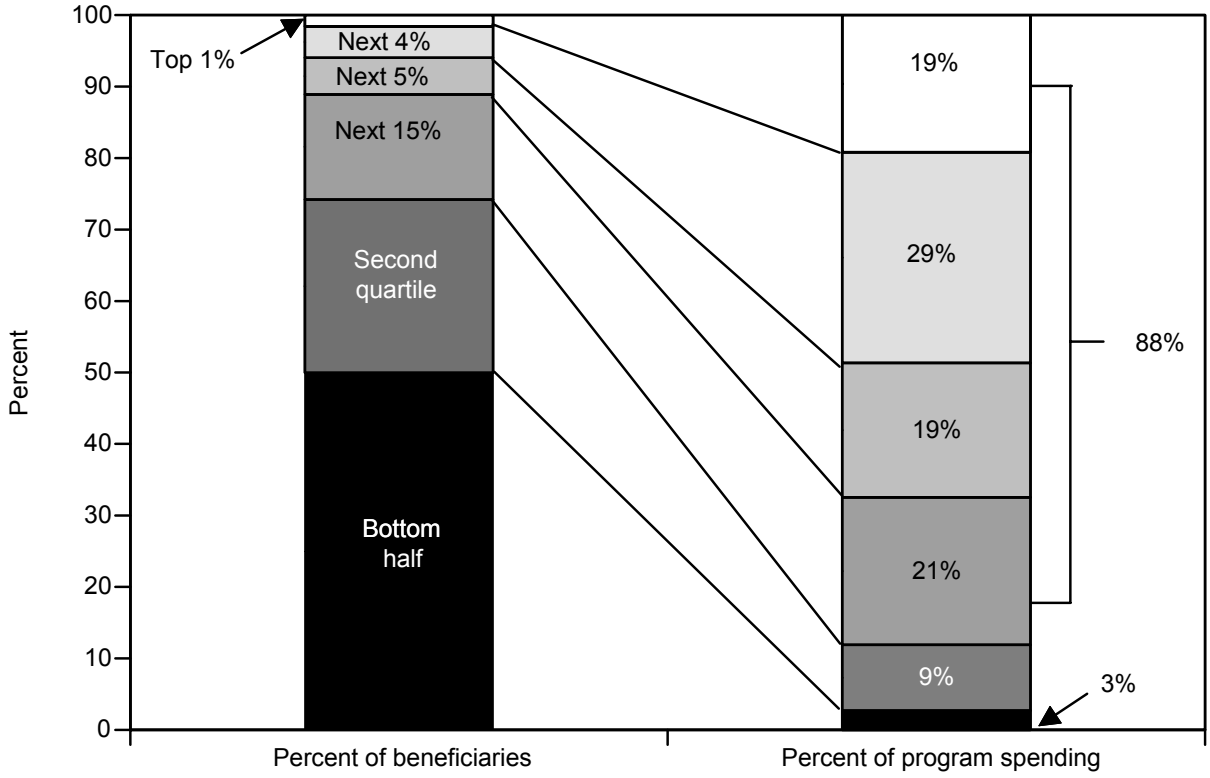
Source: CMS, Office of the Actuary, 2006.

- Medicare spending is concentrated on certain services, and the distribution among services and settings can vary substantially over time.

- In 2005, Medicare spent about $329 billion, or $8,080 per enrollee. Inpatient hospital services were by far the largest spending category (37 percent), followed by physicians (18 percent), managed care (14 percent), and other fee-for-service settings (15 percent).

- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending than it was in 1995, falling from 46 percent to 37 percent. Spending on beneficiaries enrolled in private plans has grown rapidly over the past several years, and current enrollment is higher than it was a decade ago.

Chart 1-8. FFS program spending is highly concentrated in a small group of beneficiaries, 2002



Note: FFS (fee-for-service).

Source: Direct Research, LLC, based on a 0.1 percent sample of Medicare fee-for-service enrollees and their claims.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2002, the costliest 5 percent of beneficiaries accounted for 48 percent of annual Medicare FFS spending and the costliest quartile accounted for 88 percent. By contrast, the least costly half of beneficiaries accounted for only 3 percent of FFS spending.

- Costly beneficiaries tend to include those who have multiple chronic conditions, those using inpatient hospital care, and those who are in the last year of life.

Chart 1-9. Medicare HI trust fund is projected to be insolvent in 2018

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2007	2013
Intermediate	2010	2018
Low	N/A	2041

Note: HI (hospital insurance), N/A (not available). Income includes taxes (payroll and Social Security benefits taxes, railroad retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.

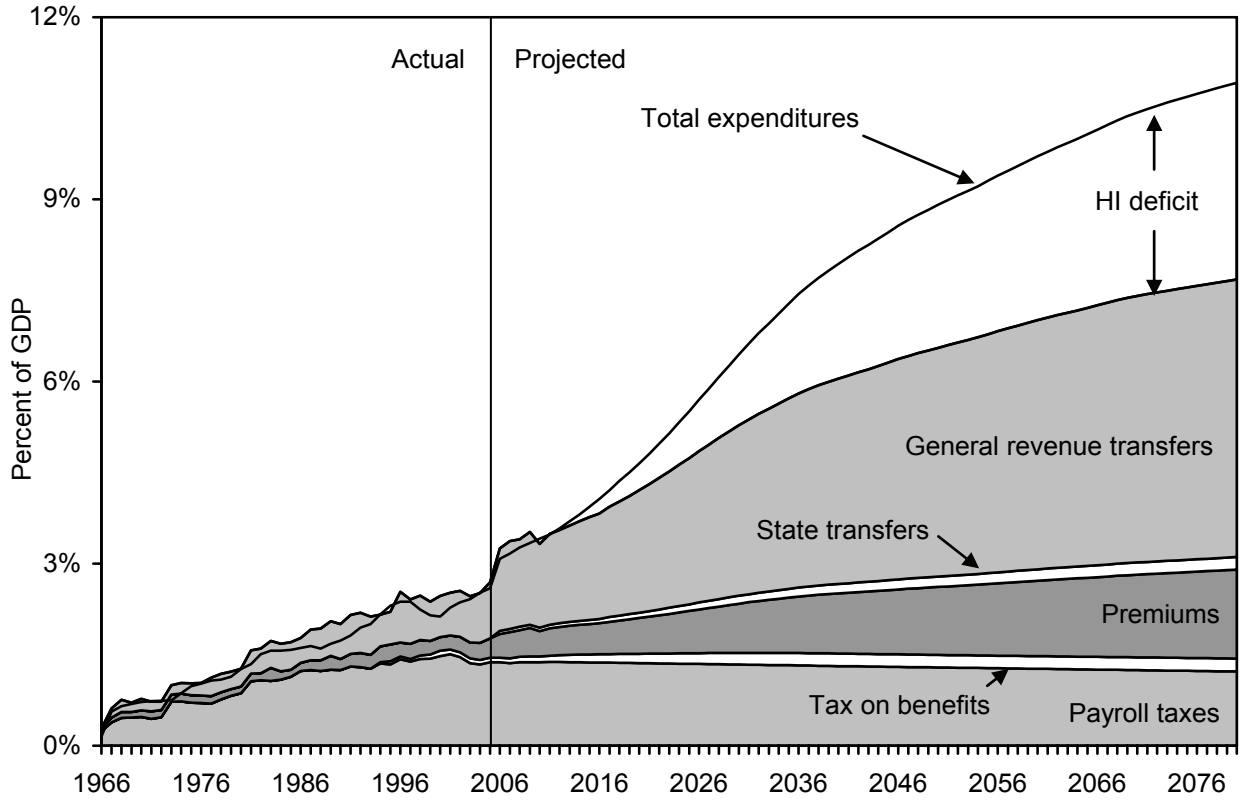
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

- The Medicare program is financed through two trust funds: one for Hospital Insurance (HI), which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's new prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use, but are made up of income and other taxes on individuals and corporations.)

- Since the SMI trust fund is financed with general revenues and beneficiary premiums, it cannot be exhausted. However, some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.

- Under high cost assumptions, the HI trust fund could be exhausted as early as 2013. Under low cost assumptions, it would remain solvent until 2041.

Chart 1-10. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (hospital insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

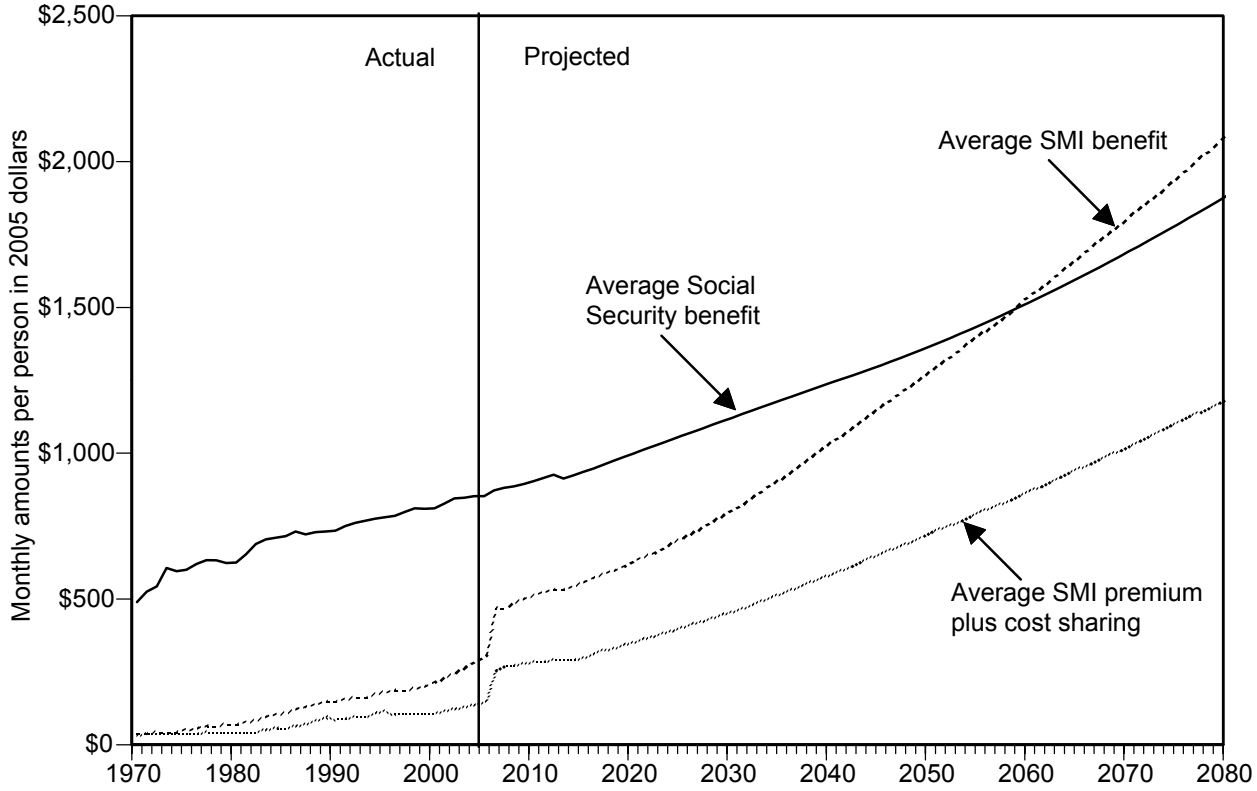
Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, trustees project that Medicare spending will grow rapidly, from about 3 percent of GDP today to 7.5 percent by 2036 and 11 percent by 2080.

- Medicare trustees project that under intermediate assumptions, the HI trust fund will be exhausted in 2018.

- Medicare's problems with long-term financing will become more prominent to policymakers over the next few years because of a warning system set up in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Each year, the trustees are required to project the share of Medicare outlays that is financed with general revenues in the current and six succeeding fiscal years. If two consecutive annual reports project that general revenue will fund 45 percent or more of Medicare outlays in any given year, then the President must propose and the Congress must consider legislation to bring Medicare's spending below this threshold. In their 2006 report, the Medicare trustees projected that the program would hit this 45 percent trigger in 2012—the last year of the seven-year projection window. If the trustees have a similar finding in their 2007 report, policymakers will be called upon to consider broad changes to Medicare's benefits and financing in the spring of 2008.

Chart 1-11. Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs prior to 2006 is not shown.

Source: 2006 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2005, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average Supplementary Medical Insurance (SMI) premiums plus cost sharing and average SMI benefits grew by more than 4 percent annually. Under current hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in a beneficiary's Social Security benefit. Recent Part B premium increases have offset about 30 percent to 40 percent of the dollar increase in the average Social Security benefit. Part D premium increases are not subject to a hold-harmless provision.

- Most beneficiaries who enroll in Medicare's new prescription drug benefit will see lower out-of-pocket (OOP) spending. Beneficiaries' OOP spending on prescription drugs prior to 2006 is not shown in this figure.

- Even with the expansion of Medicare's benefits, including prescription drugs, growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2006 and 2036, the average Social Security benefit will grow by just over 1 percent annually (after adjusting for inflation), compared with about 2.5 percent annual growth in average SMI premiums plus cost sharing.

Chart 1-12. Medicare FFS providers: Number and spending

Provider	Number of providers 2005	Projected spending FY 2005 (billions)
Inpatient hospitals	6,111[a]	$ 121.6
Hospital outpatient PPS	3,944[b]	19.6
Physicians	618,183	57.3
Skilled nursing facilities	15,625	18.1
Home health agencies	8,082	12.5
Hospices	2,852	8.3
Ambulatory surgical centers	4,506	2.8[c]
Free-standing dialysis facilities	3,898	7.3
Outpatient clinical laboratories	192,533	6.4
Durable medical equipment suppliers	~140,000[d]	7.8

Note: FFS (fee-for-service), FY (fiscal year), PPS (prospective payment system). Data include program spending only and do not include cost sharing or administrative expenses.
[a]Short-stay and nonshort-stay hospitals.
[b]Data are for first quarter of 2006. Analysis does not include alcohol and drug abuse hospitals and critical access hospitals, but does include psychiatric, rehabilitation, and children's hospitals that bill under the outpatient PPS.
[c]Preliminary.
[d]Data are for 2006. Many suppliers do not file a claim every year. For example, in a sample of 2004 claims, about 70,000 suppliers filed claims for reimbursement.

Source: Number of providers comes from a variety of CMS databases, including the Office of Research, Development, and Information 2005 Wallet Card of CMS program data; the Provider of Services file; the Online Survey, Certification, and Reporting system; Standard Analytic files; the Dialysis Facility Compare file; the CMS Clinical Laboratory Improvement Act database; and unpublished CMS data.

- The most numerous Medicare providers are physicians, followed by outpatient laboratories and durable medical equipment suppliers.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

  http://www.cms.hhs.gov/ReportsTrustFunds/

- The National Health Expenditure Accounts developed by the Office of the Actuary at CMS provide information for health care in the United States.

  http://cms.hhs.gov/NationalHealthExpendData/

- The CMS chart series provides information on the U.S. health care system and Medicare program spending.

  http://www.cms.gov/TheChartSeries/

- The Congressional Budget Office provides projections of Medicare spending.

  http://www.cbo.gov/budget/factsheets/2006b/medicare.pdf

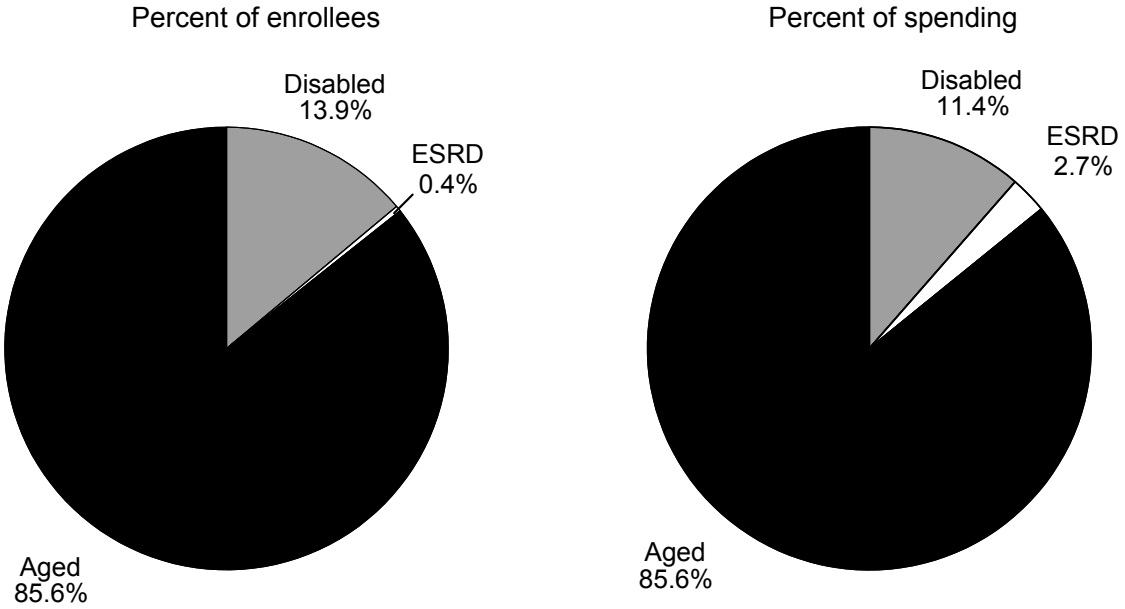
- Chapter 1 of MedPAC's March 2006 Report to the Congress provides an overview of Medicare and U.S. health care spending.

  http://www.medpac.gov/publications/congressional_reports/mar06_ch01.pdf

SECTION 2

Medicare beneficiary demographics

Chart 2-1. Aged beneficiaries account for the greatest share of the Medicare population and program spending, 2003

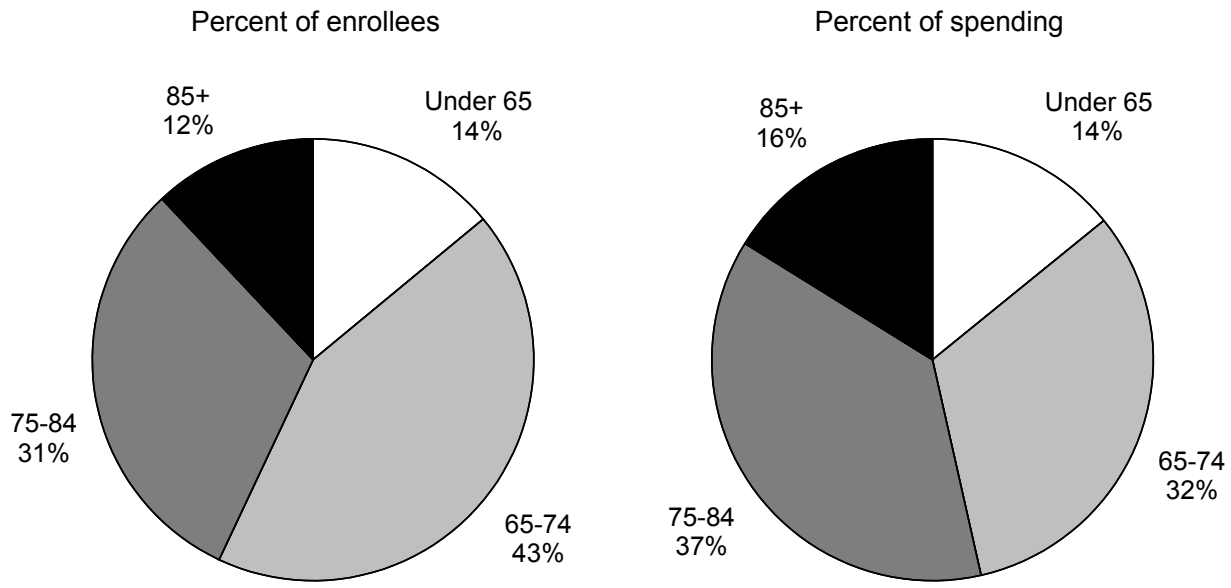


Note: ESRD (end-stage renal disease) refers to beneficiaries under age 65 with ESRD. The disabled category refers to beneficiaries under age 65 without ESRD. The aged category refers to beneficiaries age 65 and older. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- The highest percentage of Medicare expenditures is for aged beneficiaries, reflecting their greater share of the Medicare population.
- A disproportionate share of Medicare expenditures is devoted to Medicare beneficiaries who are eligible due to end-stage renal disease (ESRD). On average, ESRD beneficiaries cost at least five times as much as beneficiaries in other categories: $6,367 is spent per aged beneficiary, $5,419 per (non-ESRD) disabled beneficiary, and $43,057 per ESRD beneficiary. On average, Medicare spending per beneficiary is $6,602.

Chart 2-2. Medicare spending rises as beneficiaries age, 2003



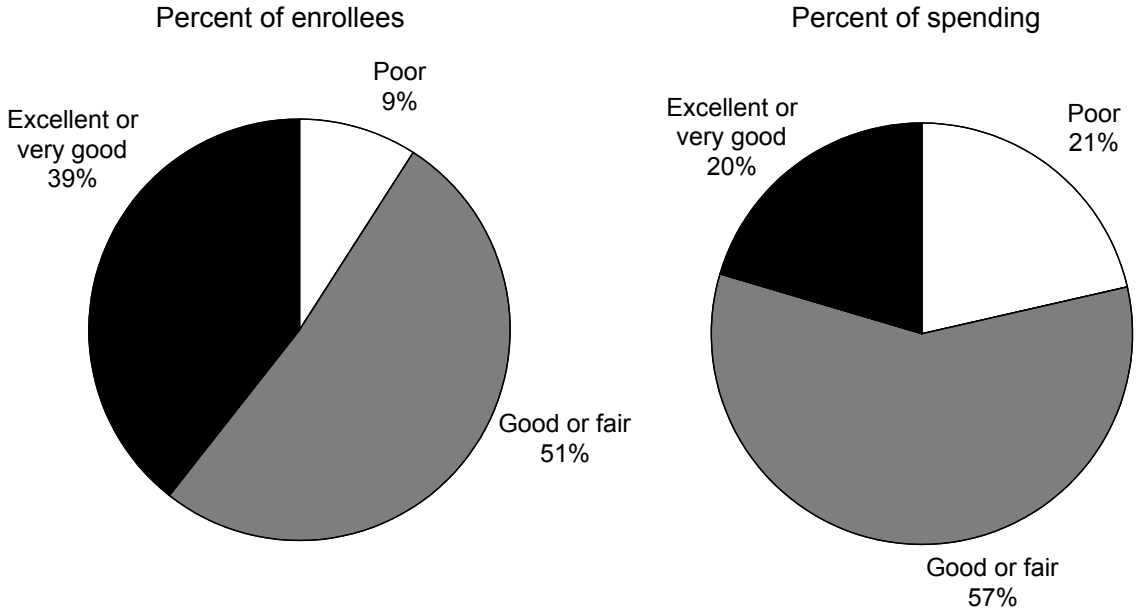
Note: Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Per capita expenditures increased by about $2,000 for each age group over 65: Per capita expenditures were $5,042 for those ages 65 to 74, $7,789 for those 75 to 84, and $9,243 for those 85 and older. Per capita expenditures for Medicare beneficiaries under age 65, enrolled due to disability (both end-stage renal disease and non-ESRD), were $6,513. On average, Medicare spending per beneficiary was $6,602.

- In each age group, much of the spending is concentrated among people with chronic conditions and those who die.

Chart 2-3. Beneficiaries who report being in poor health account for a disproportionate share of Medicare spending, 2003

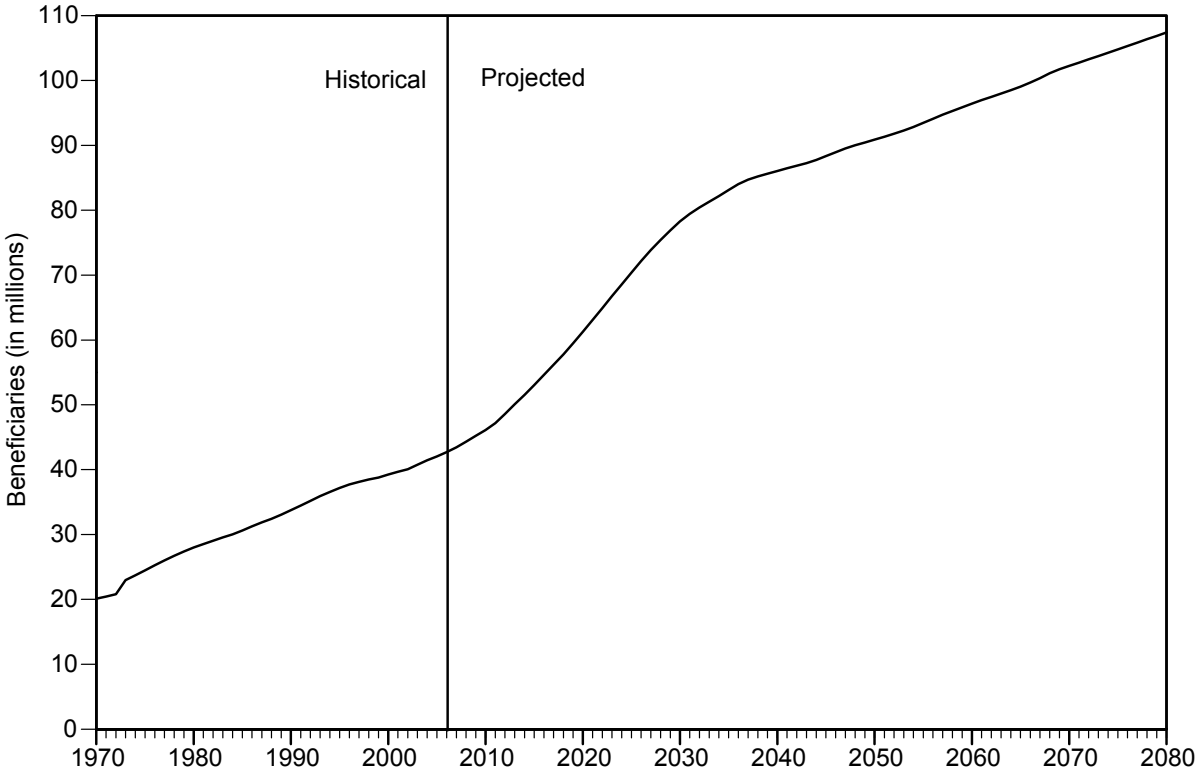


Note: Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Most beneficiaries report relatively good health. Less than 10 percent report poor health.
- Medicare spending is strongly associated with self-reported health status. Per capita expenditures for those with excellent health are $3,455; $7,478 for those with good or fair health; and $14,689 for those with poor health. On average, Medicare spending per beneficiary is $6,602.

Chart 2-4. Enrollment in the Medicare program is projected to grow fastest in the next 30 years



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

Source: MedPAC analysis of the Social Security Administration 2006 Trustees Report, Intermediate Assumptions.

- The total number of people enrolled in the Medicare program will nearly double between 2000 and 2030, from about 40 million to 79 million beneficiaries.
- The rate of increase in Medicare enrollment will accelerate around 2010 when members of the "baby boom" generation start to become eligible and will slow around 2030 when the entire baby boom generation has become eligible.

Chart 2-5. Characteristics of the Medicare population, 2003

Characteristic	Percent of the Medicare population	Characteristic	Percent of the Medicare population
Total (41,808,391*)	100%		
Sex		**Education**	
Male	44	No high school diploma	30%
Female	56	High school diploma only	30
		Some college or more	39
Race/ethnicity			
White, non-Hispanic	78	**Income status**	
African American, non-Hispanic	10	Below poverty	19
Hispanic	8	100–125% of poverty	11
Other	4	125–200% of poverty	21
Age		200–400% of poverty	29
< 65	17	Over 400% of poverty	20
65–74	35		
75–84	32	**Supplemental insurance status**	
85+	16	Medicare only	10
Health status		Managed care	13
Excellent or very good	37	Employer	33
Good or fair	53	Medigap	21
Poor	10	Medigap/employer	4
Residence		Medicaid	16
Urban	73	Other	2
Rural	27		
Living arrangement			
Institution	8		
Alone	29		
Spouse	44		
Other	19		

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2003, poverty was defined as $8,825 for people living alone and as $11,133 for married couples. Totals may not sum to 100 percent due to rounding.
*Based on a representative sample of the Medicare population.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- The Medicare population tends to be female, white, between the ages of 65 and 84, in good or fair health, and living with a spouse. Most beneficiaries live in urban areas, have graduated from high school, and have some form of supplemental insurance coverage. Half have incomes under 200 percent of poverty.

Chart 2-6. Characteristics of the Medicare population, by rural and urban residence, 2003

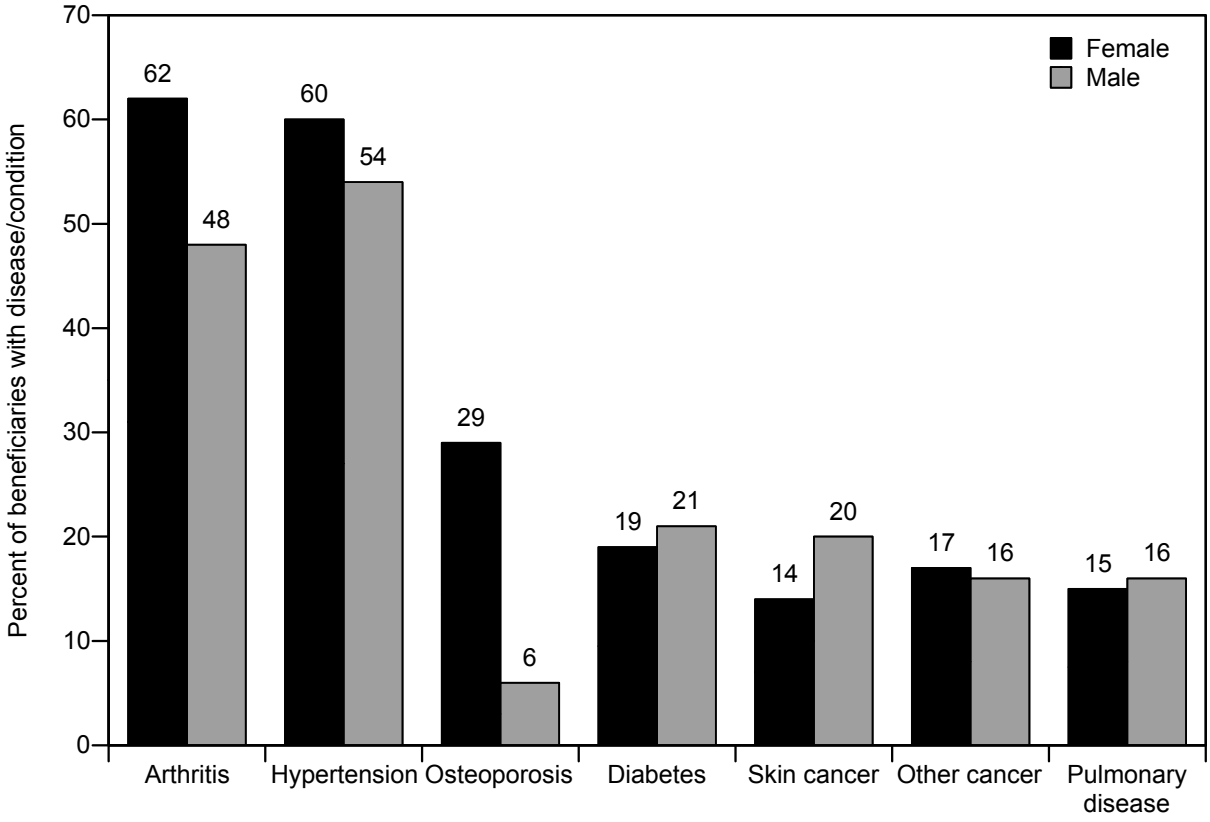
Characteristics	Percent of urban Medicare population	Percent of rural Medicare population
Total	100%	100%
Urban 73%		
Rural 27%		
Sex		
Male	44	46
Female	56	54
Race/ethnicity		
White, non-Hispanic	76	86
African American, non-Hispanic	10	7
Hispanic	9	3
Other	4	4
Age		
< 65	14	16
65–74	43	43
75–84	32	29
85+	12	11
Health status		
Excellent or very good	40	36
Good or fair	51	51
Poor	8	12
Income status		
Below poverty	15	19
100–125% of poverty	10	12
125–200% of poverty	20	23
200–400% of poverty	30	31
Over 400% of poverty	25	16

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2003, poverty was defined as $8,825 for people living alone and as $11,133 for married couples. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Close to one-fourth of all beneficiaries reside in rural areas.
- Rural Medicare beneficiaries are more likely to be white (86 vs. 76 percent), to report being in poor health (12 vs. 8 percent), and to have income below 125 percent of poverty (31 vs. 25 percent), compared to urban beneficiaries.

Chart 2-7. Arthritis and hypertension are the most common diseases reported by Medicare beneficiaries, 2002



Source: CMS, Office of Research, Development, and Information.

- Arthritis, hypertension, osteoporosis, and diabetes are among the most prevalent chronic conditions reported by Medicare beneficiaries.
- Female beneficiaries live longer, and the risk of chronic disease increases with age. Female beneficiaries are more likely than male beneficiaries to have arthritis, hypertension, or osteoporosis.

Web links. Medicare beneficiary demographics

- The CMS Chart series provides a profile of Medicare beneficiaries.

  http://www.cms.gov/TheChartSeries/downloads/Sec3b_p.pdf

- The CMS Data Compendium contains historic, current, and projected data on Medicare enrollment.

  http://www.cms.hhs.gov/DataCompendium/02_2003_Data_Compendium.asp#TopofPage

- The CMS website provides information on Medicare enrollment by state.

  http://www.cms.hhs.gov/MedicareEnRpts

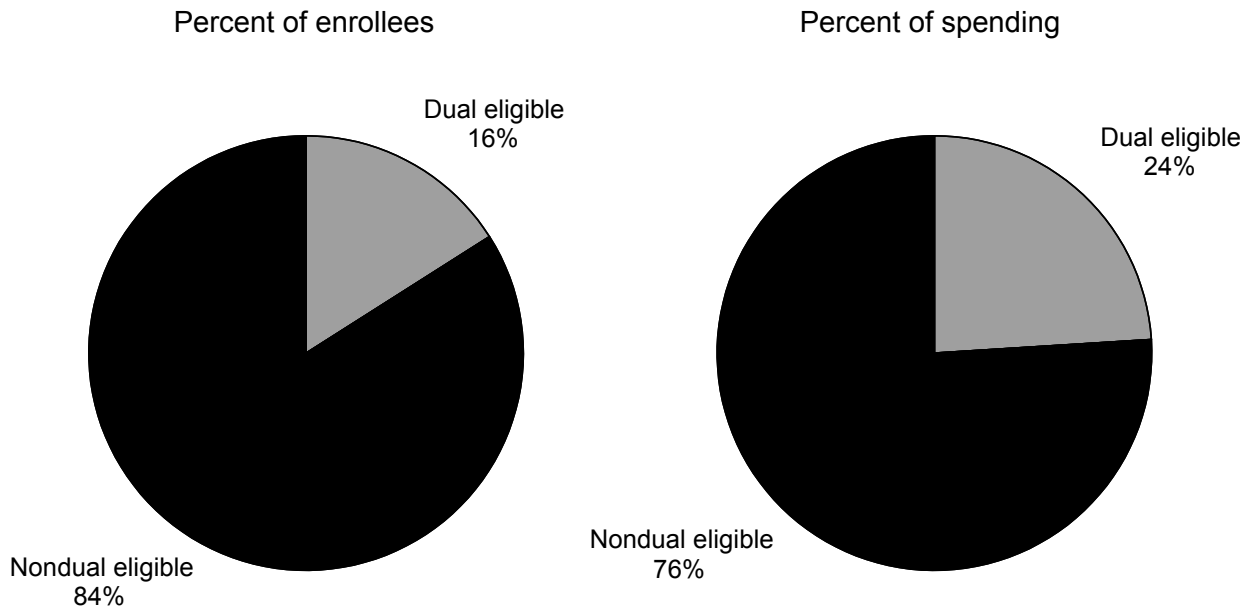
- The CMS website provides information about the Medicare Current Beneficiary Survey, a resource on the demographic characteristics of Medicare beneficiaries.

  http://www.cms.hhs.gov/mcbs/

SECTION 3

Dual-eligible beneficiaries

Chart 3-1. Dual-eligible beneficiaries account for a disproportionate share of Medicare spending, 2003

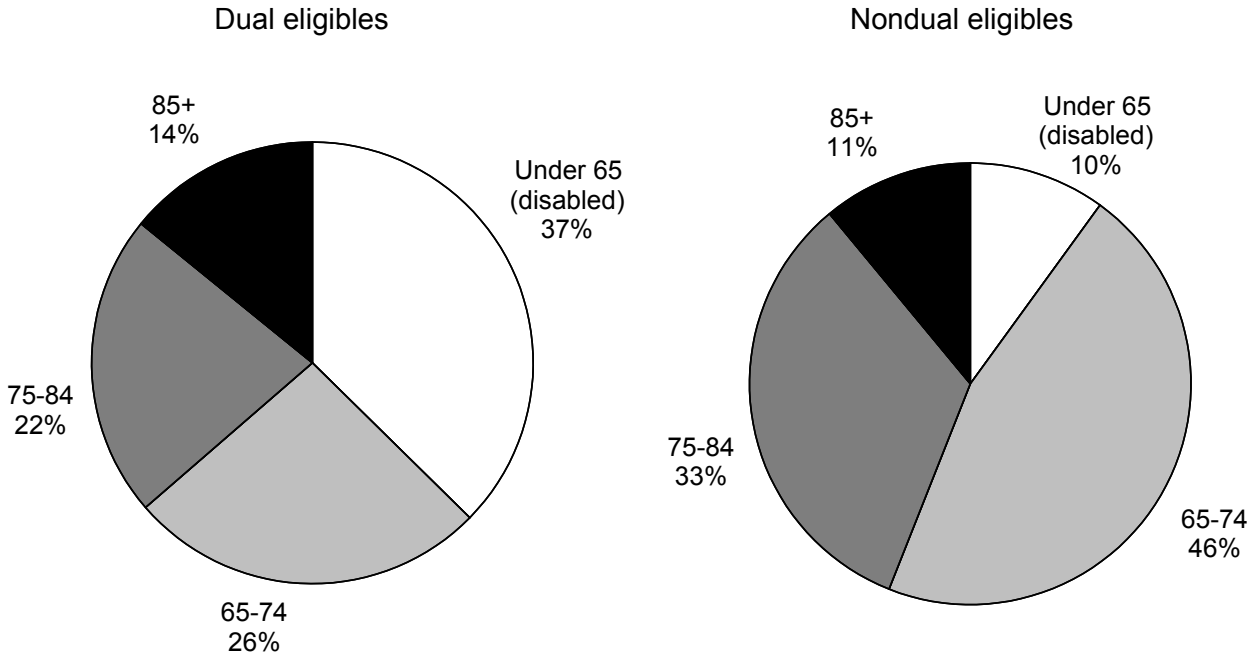


Note: Dual eligibles are designated as such if the months they qualify for Medicaid exceed months they qualify for other supplemental insurance.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help low-income persons obtain needed health care.
- A disproportionate share of Medicare expenditures is spent on dual-eligible beneficiaries: Dual eligibles account for 16 percent of Medicare beneficiaries and 24 percent of Medicare spending.
- Dual eligibles cost Medicare about 1.6 times as much as nondual eligibles: $9,595 is spent per dual-eligible beneficiary, and $6,023 is spent per nondual-eligible beneficiary.
- Total spending—which includes spending by Medicare, Medicaid, supplemental insurance, and out-of-pocket across all payers—for dual eligibles averaged about $20,941 per person in 2003, almost twice the amount for other Medicare beneficiaries.

Chart 3-2. Dual eligibles are more likely than nondual eligibles to be disabled or over 85 years old, 2003

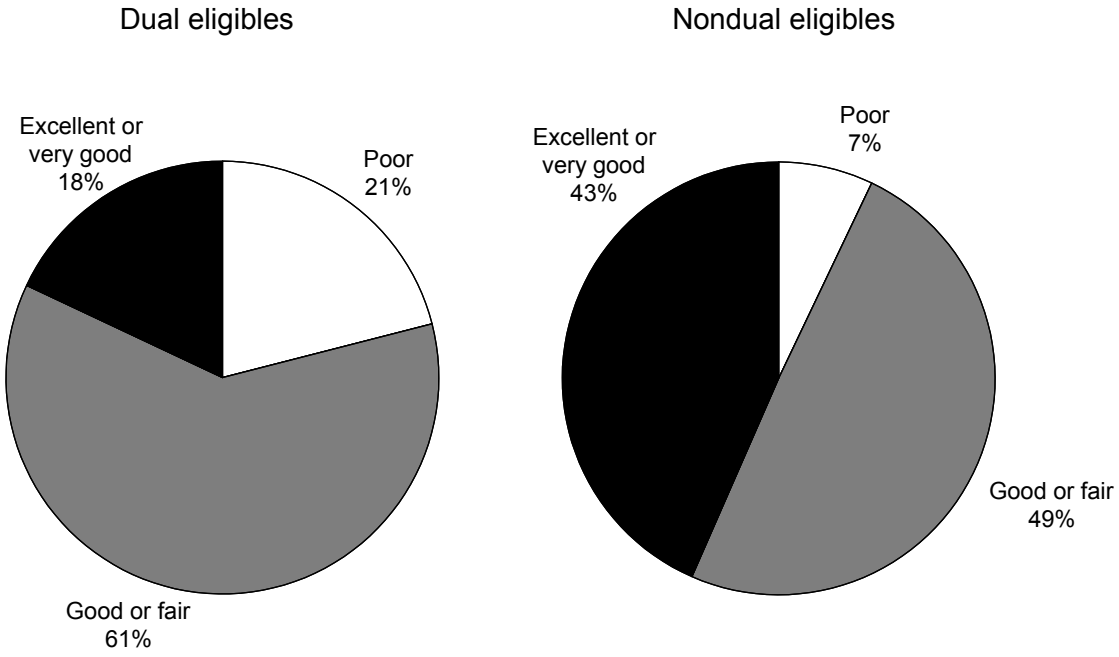


Note: Beneficiaries who are under age 65 qualify for Medicare because they are disabled. Once disabled beneficiaries reach age 65, they are counted as aged.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- More than one-third of dual eligibles are disabled, compared with only 10 percent of the nondual-eligible population. Dual eligibles are also somewhat more likely than nondual eligibles to be age 85 or older.

Chart 3-3. Dual eligibles are more likely than nondual eligibles to report poorer health status, 2003



Note: Totals may not sum to 100 percent due to missing responses.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Relative to nondual eligibles, dual eligibles report poorer health status. The majority report good or fair status, but about 20 percent of the dual-eligible population report being in poor health (compared with less than 10 percent of the nondual-eligible population).
- Dual eligibles are more likely to suffer from cognitive impairment and mental disorders, and they have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease than do nondual eligibles.
- Nineteen percent of dual eligibles reside in institutions, compared with 2 percent of nondual eligibles.

Chart 3-4. Demographic differences between dual eligibles and nondual eligibles, 2003

Characteristic	Percent of dual-eligible beneficiaries	Percent of nondual-eligible beneficiaries
Sex		
Male	37%	45%
Female	63	55
Race/ethnicity		
White, non-Hispanic	54	83
African American, non-Hispanic	22	7
Hispanic	16	6
Other	8	3
ADLs		
No ADLs	46	70
1–2 ADLs	23	19
3–6 ADLs	31	10
Residence		
Urban	72	77
Rural	28	23
Living arrangement		
Institution	19	2
Alone	30	28
Spouse	18	55
Children, nonrelatives, others	32	14
Education		
No high school diploma	57	25
High school diploma only	23	31
Some college or more	17	43
Income status		
Below poverty	57	8
100–125% of poverty	21	8
125–200% of poverty	15	21
200–400% of poverty	4	35
Over 400% of poverty	1	27
Supplemental insurance status		
Medicare or Medicare/Medicaid only	91	12
Medicare managed care	1	15
Employer	1	40
Medigap	1	25
Medigap/employer	0	5
Other*	7	2

Note: ADL (activity of daily living). Dual eligibles are designated as such if the months they qualify for Medicaid exceed the months they qualify for other supplemental insurance. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2003, poverty was defined as $8,825 for people living alone and $11,133 for married couples. Totals may not sum to 100 percent due to rounding.
*Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Dual eligibles qualify for Medicaid due to low incomes: Fifty-seven percent live below the poverty level, and 93 percent live below 200 percent of poverty. Compared to nonduals, dual eligibles are more likely to: be female, African American, or Hispanic; lack a high school diploma; have greater limitations in activities of daily living; reside in a rural area; and live in an institution, alone, or with persons other than a spouse.

Chart 3-5. Differences in spending and service use between dual eligibles and nondual eligibles, 2003

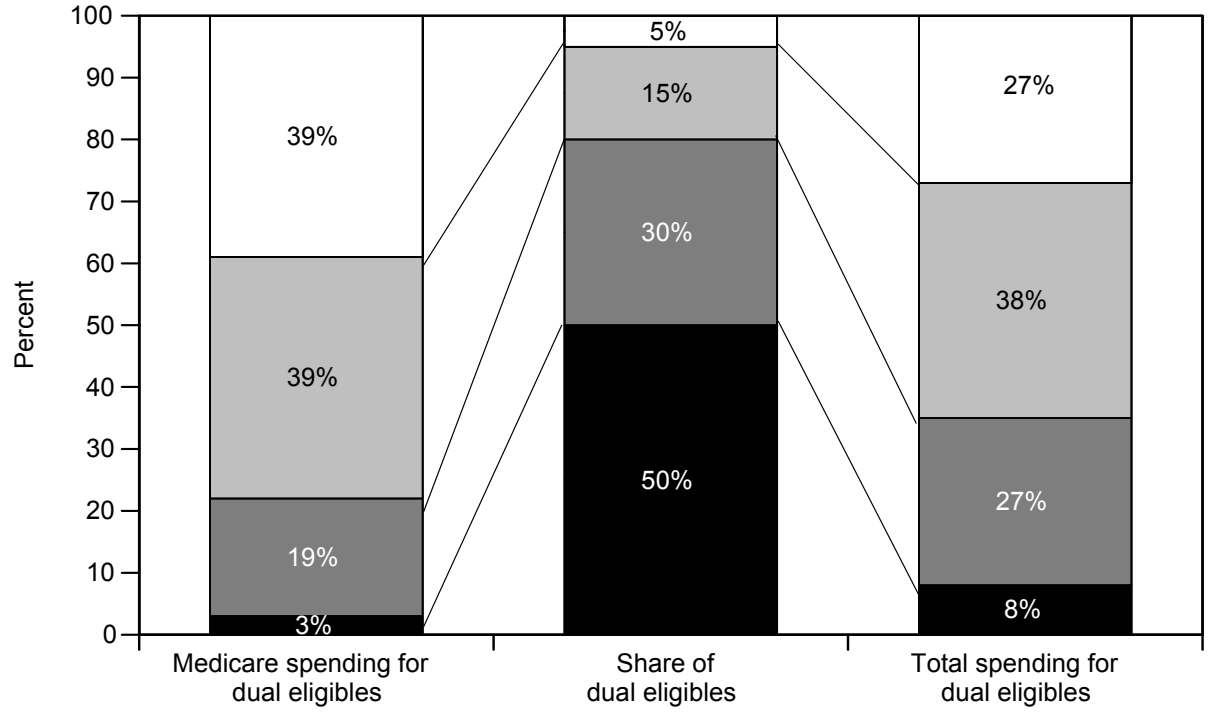
Service	Dual-eligible beneficiaries	Nondual-eligible beneficiaries
Average Medicare payment for all beneficiaries		
Total Medicare payments	$9,595	$6,023
Inpatient hospital	4,224	2,250
Physician[a]	2,640	1,584
Outpatient hospital	1,149	520
Home health	564	206
Skilled nursing facility[b]	697	257
Hospice	204	131
Percent of beneficiaries using service		
Percent using any type of service	92.5%	87.8%
Inpatient hospital	27.2	16.3
Physician[a]	90.5	74.2
Outpatient hospital	72.2	54.0
Home health	10.8	5.7
Skilled nursing facility[b]	8.1	3.1
Hospice	2.3	1.5

Note: [a]Includes a variety of medical services, equipment, and supplies.
[b]Individual short-term facility (usually skilled nursing facility) stays for the Medicare Current Beneficiary Survey population.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2003, which updates the previous analysis by Liu et al. in 1998.

- Average per capita spending for dual eligibles is 53 percent higher than for nondual eligibles—$9,595 compared to $6,023.
- For each type of service, average Medicare per capita payments are higher for duals than nonduals. The largest percentage difference between the two groups is in skilled nursing facility (SNF) and home health services, for which Medicare spends over twice as much on duals as on nonduals.
- Higher average per capita spending for duals is a function of both a higher proportion of duals using services than nonduals, as well as greater volume or intensity of use among those using services. A higher proportion of duals than nonduals use at least one Medicare-covered service—93 versus 88 percent.
- Duals are more likely to use each type of Medicare-covered service than nonduals; for example, duals are more than twice as likely to use SNF services.

Chart 3-6. Both Medicare and total spending are concentrated among dual-eligible beneficiaries, 2003



Note: Total spending includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use files, 2003.

- Annual Medicare spending is concentrated among a small number of dual-eligible beneficiaries. The costliest 20 percent of duals accounts for 78 percent of Medicare spending on duals; in contrast, the least costly 50 percent of duals accounts for only 3 percent of Medicare spending on duals. Of the 1 percent of all beneficiaries for whom Medicare spending is the highest, one-third are dual eligible. Similarly, of the costliest 5 percent of beneficiaries, a quarter are dual eligible.

- The distribution of total spending for dual eligibles is similar, but somewhat less concentrated than the distribution of Medicare spending. For example, the top 5 percent of duals accounts for 27 percent of total spending, which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending (compared with 39 percent of Medicare spending).

- On average, total spending for duals is almost twice as high as that for nonduals—$20,941 compared to $11,377.

Chart 3-7. Dual-eligible beneficiaries report generally good access to care

Question	Dual-eligible beneficiaries	Nondual-eligible beneficiaries
Do you have a personal doctor or nurse?		
Yes	83.1%	90.4%
In the last 6 months, if you needed care right away, did you usually or always get care as soon as you wanted?		
Yes	87.8	93.0
In the last 6 months, if you made any appointments with a doctor or health care provider, how often did you get an appointment as soon as you wanted?		
Usually or always	85.8	92.2

Source: MedPAC analysis of CAHPS (Consumer Assessment of Health Plans Survey) for fee-for-service Medicare, 2004.

- Dual-eligible beneficiaries often possess characteristics associated with needing care—limitations in activities of daily living and poor health status, for example—as well as having difficulty obtaining care—such as being poor and poorly educated.
- Survey results indicate that most duals report generally good access to care, although somewhat lower than beneficiaries with other sources of supplemental insurance.

Web links. Dual-eligible beneficiaries

- Chapter 3 of the MedPAC June 2004 Report to the Congress provides further information on dual-eligible beneficiaries.

  http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf

- The Kaiser Family Foundation provides information on dual-eligible beneficiaries.

  http://kff.org

- The CMS Medicaid Chartbook provides information on the Medicaid program.

  http://www.cms.hhs.gov/thechartseries/downloads/2tchartbk.pdf

SECTION 4

Quality of care in the Medicare program

Chart 4-1. Hospital mortality decreased from 2000 to 2004

Diagnosis or procedure	Risk-adjusted rates per 10,000			Percent change 2000–2004	Number of cases in 2004
	2000	2002	2004		
In-hospital mortality					
Pneumonia	1,012	949	789	−22.0%	66,100
AMI	1,414	1,309	1,110	–21.4	36,548
Stroke	1,212	1,159	1,019	−15.9	34,387
CHF	541	474	358	–33.9	35,218
GI hemorrhage	400	355	264	–34.0	10,365
CABG	482	427	355	–26.4	7,119
Craniotomy	986	930	814	–17.4	3,281
AAA repair	1,161	1,130	956	–17.7	1,595
30-day mortality					
Pneumonia	1,377	1,557	1,452	5.5	118,367
AMI	1,627	1,690	1,570	–3.5	50,839
Stroke	1,620	1,807	1,767	9.1	57,128
CHF	818	907	834	2.0	72,265
GI hemorrhage	590	649	587	–0.5	20,593
CABG	441	412	366	–17.1	7,078
Craniotomy	1,123	1,182	1,094	–2.6	4,321
AAA repair	1,069	1,072	912	–14.7	1,534

Note: AMI (acute myocardial infarction), CHF (congestive heart failure), GI (gastrointestinal), CABG (coronary artery bypass graft), AAA (abdominal aortic aneurysm). Rate is for discharges eligible to be counted in the measure.

Source: MedPAC analysis of MedPAR discharges using Agency for Healthcare Research and Quality indicators and methods.

- Rates of in-hospital mortality generally decreased between 2000 and 2004 on all conditions and procedures measured. The most substantial improvements occurred for congestive heart failure, gastrointestinal hemorrhage, and coronary artery bypass graft.
- Thirty-day mortality (as measured from admission) has also generally decreased, though the rate of mortality following pneumonia, stroke, and congestive heart failure rose over the period.

Chart 4-2. Hospital processes of care improving, but many rates still low, 2001–2004

Indicator	Average state rate: Baseline 2001 Q1–Q3	Average state rate: 2004 Q4	Difference
AMI			
Aspirin at arrival	81.4%	87.6%	6.2%
Aspirin prescribed at discharge	84.0	91.8	7.8
ACEI or ARB for LVSD* **	63.5	71.6	8.1
Adult smoking cessation advice/counseling	42.2	74.7	32.5
Beta blocker prescribed at discharge	71.1	90.7	19.6
Beta blocker at arrival	61.4	82.3	20.9
Mean time to thrombolysis (in minutes)	N/A	58.5	N/A
Thrombolytic agent received within 30 minutes of hospital arrival	28.9	37.7	8.8
Mean time to PCI (in minutes)	N/A	196.5	N/A
PCI received within 120 minutes of hospital arrival	29.2	56.2	27.0
Heart failure			
Discharge instructions	3.8	20.7	16.9
LVF assessment	70.2	83.8	13.6
ACEI or ARB for LVSD* **	68.3	65.8	–2.5
Adult smoking cessation advice/counseling	29.1	59.7	30.6
Pneumonia			
Initial antibiotic received within 4 hours of hospital arrival	61.5	71.0	9.5
Initial antibiotic selection for community-acquired pneumonia in immunocompetent patient	58.9	75.0	16.1
Blood culture performed within 24 hours prior to or after hospital arrival	63.7	71.9	8.2
Blood culture performed before first antibiotic received in hospital	81.1	83.8	2.7
Influenza vaccination	13.8	43.8	30.0
Pneumococcal vaccination	16.5	50.1	33.6
Adult smoking cessation advice/counseling	N/A	57.1	N/A
Oxygenation assessment	94.6	99.0	4.4
SIP			
Prophylactic antibiotic received within 1 hour prior to surgical	47.6	69.7	22.1
Prophylactic antibiotic selection for surgical patients	91.4	92.2	0.8
Prophylactic antibiotics discontinued within 24 hours after surgery	40.7	52.9	12.2

Note: AMI (acute myocardial infarction), ACEI (angiotensin-converting enzyme inhibitor), ARB (angiotensin receptor blocker), LVSD (left ventricular systolic dysfunction), LVF (left ventricular function), N/A (not available), PCI (percutaneous coronary intervention), SIP (surgical infection prevention). The rates are means of state rates.
*During this time clinicians began to use another drug therapy for this condition, replacing ACEIs in some cases.
**Measure revised to incorporate ARBs November 2004.

Source: MedPAC analysis of CMS data from the quality improvement organization program.

- The rates reflect the percentage of beneficiaries receiving clinically indicated services (100 percent is the goal on most measures). Many of the rates remain too low.
- Of the measures that had rates for both periods, 21 out of 22 improved. One of the measures (ACEI for LVSD for heart failure) may have decreased due to a change in clinical practice.

Chart 4-3. Safety of care: Adverse events affect many hospitalized beneficiaries, 2000–2004

	Risk-adjusted rates per 10,000			Difference	Observed adverse
	2000	2002	2004	2000–2004	events, 2004
Decubitus ulcer	225	251	276	51	156,961
Failure to rescue	1,450	1,330	1,114	–336	67,098
Postoperative PE or DVT	71	86	98	27	42,105
Accidental puncture/ laceration	32	36	34	2	38,258
Infection due to medical care	20	24	25	5	32,408
Iatrogenic pneumothorax	8	8	8	0	10,953
Postoperative respiratory failure	34	46	53	19	10,914
Postoperative sepsis	97	111	131	34	8,600
Postoperative hemorrhage or hematoma	20	17	17	–3	7,365
Postoperative physiologic and metabolic derangement	5	6	8	3	2,643
Postoperative wound dehiscence	14	15	12	–2	1,911
Postoperative hip fracture	3	3	3	0	1,127

Note: PE (pulmonary embolism), DVT (deep vein thrombosis). Rate is for discharges eligible to be counted in the measure.

Source: MedPAC analysis of 100 percent of MedPAR discharges using Agency for Healthcare Research and Quality indicators and methods.

- From 2000 to 2004, 7 of 12 rates of adverse events experienced by Medicare beneficiaries increased.
- Four of the indicators have seen decreasing rates; these include failure to rescue, one of the most common and—because it results in death—most severe.

Chart 4-4. Rates of potentially avoidable admissions, 2002−2004

	Rates per 10,000 beneficiaries		
	2002	2004	Difference
Congestive heart failure	1,054	1,085	31*
COPD/Asthma	771	710	–61
Diabetes long-term complications	191	168	–23
Diabetes short-term complications	40	31	–9
Hypertension	10	10	0
Unstable angina/ED**	10	7	–3

Note: COPD (chronic obstructive pulmonary disease). ED (emergency department). The group studied excludes those under 65, those in Medicare Advantage plans, hospice users, anyone not continuously enrolled for one of two time periods (2001–2002 or 2003–2004), and those living outside the United States.
*Not a statistically significant result. All others are statistically significant at a 95 percent confidence level ($p<0.05$).
**This measures visits to the emergency department, not admissions.

Source: MedPAC analysis of 5 percent sample of beneficiaries' outpatient and inpatient claims for 2002 and 2004.

- Potentially avoidable admissions are admissions that high-quality ambulatory care has been shown to prevent. The populations measured are those with a diagnosis previous to the admission for the condition, not the overall population. For example, this table counts the percent of Medicare beneficiaries with congestive heart failure who were admitted to the hospital.
- Four out of six rates of potentially avoidable admissions (for persons with these conditions) decreased.
- Notable, given the amount of emphasis CMS and others have placed on improving diabetes care, is the decrease in potentially avoidable admissions for beneficiaries with diabetes, both for long- and short-term complications.
- Among these conditions, rates of potentially avoidable admissions are highest for congestive heart failure.

Chart 4-5. Most ambulatory care indicators show improvement or stability, 2002−2004

Indicators by condition	Number of indicators			
	Improved	Stable	Worsened	Total
All	20	15	3	38
Anemia and GI bleed	3	1	0	4
CAD	3	1	0	4
Cancer	0	4	3	7
CHF	5	3	0	8
COPD	2	0	0	2
Depression	0	1	0	1
Diabetes	6	1	0	7
Hypertension	0	1	0	1
Stroke	1	3	0	4

Note: GI (gastrointestinal), CAD (coronary artery disease), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of Medicare Ambulatory Care Indicators for the Elderly from the Medicare 5 percent Standard Analytic Files.

- The Medicare Ambulatory Care Indicators for the Elderly (MACIEs) track the provision of necessary care and rates of potentially avoidable hospitalizations.
- Out of 38 indicators, 20 improved, 15 did not change, and 3 worsened from 2002 to 2004.
- This finding suggests that in 2004 beneficiaries with these conditions were somewhat more likely to receive necessary care and avoid hospitalizations.
- For several conditions, declines in potentially avoidable hospitalizations occur concurrently with the provision of necessary clinical care for that condition.

Chart 4-6. Patient-centeredness of care: Beneficiaries rate interactions with health care providers highly

Question	2000	2002	2004
Do you have a personal doctor or nurse? Yes	N/A	89.0%	90.0%
Care *(Percent who rated provider 8 or higher on a scale of 0 to 10)*			
How would you rate your personal doctor or nurse?	84.7%	83.7	84.7
How would you rate the specialist you saw most often in the last 6 months, including a personal doctor if he or she is a specialist?	85.5	84.4	85.1*
How would you rate all the health care you got in the last 6 months from all doctors and other health providers?	85.4	85.2	86.4*
Quality of interactions			
In the last 6 months, how often did doctors or other health providers:			
Usually or always listen carefully to you?	94.8	94.6	94.6*
Usually or always explain things in a way you could understand?	93.4	93.8	93.9*
Usually or always show respect for what you had to say?	94.9	94.8	94.8
Usually or always spend enough time with you?	91.1	90.6	90.9

Note: N/A (not available).
*Indicates a statistically significant change between 2000 and 2004, at a 95 percent confidence level ($p<0.05$).

Source: MedPAC analysis of Consumer Assessment of Health Plans Survey (CAHPS) for fee-for-service Medicare, 2000–2004.

- More than 80 percent of beneficiaries gave a rating of 8 or higher on a scale of 0 to 10 (10 being the highest) to their personal doctor or nurse and the specialist that they saw most often in the last 6 months. The same was true for all the health care they received in the last 6 months.
- They also highly rate the quality of interactions with their doctor or other health provider. For example, in 2004, between 93 percent and 95 percent of beneficiaries reported that their doctors or other health care providers usually or always listened carefully to them, explained things in a way that they could understand, and showed respect for what they had to say.

Chart 4-7. Share of home health patients achieving positive outcomes continues to increase

Measure	June 2002–May 2003	June 2003–May 2004	June 2004–May 2005
Improvement in:			
Walking around	34%	36%	38%
Getting out of bed	49	51	52
Bathing	57	60	61
Managing oral medications	35	38	39
Patients have less pain	57	59	61
Any hospital admissions	28	28	28
Any unplanned ER use	21	21	21

Note: ER (emergency room).

Source: MedPAC analysis of CMS Home Health Compare data.

- Each measure of quality from CMS's public website Home Health Compare has shown small improvement.

Chart 4-8. The quality of dialysis care has generally improved

Outcome measure	2000	2001	2002	2003
Percent of in-center hemodialysis patients:				
Receiving adequate dialysis	91%	92%	92%	94%
With anemia under control	71	75	78	81
Dialyzed with an AV fistula	30	31	33	35
Not malnourished	80	82	81	81
Percent of peritoneal dialysis patients:				
Receiving adequate CAPD	69	68	71	70
Receiving adequate CCPD	62	70	66	65
With anemia under control	75	76	81	83
Not malnourished	56	61	60	63

Note: AV (arteriovenous), CAPD (continuous ambulatory peritoneal dialysis), CCPD (continuous cycler-assisted peritoneal dialysis). Data on dialysis adequacy, use of fistulas, and anemia management represent percent of patients meeting CMS's clinical performance criteria. Not malnourished includes patients with a serum albumin $\geq$3.5/3.2 g/dL.

Source: Compiled by MedPAC from 2000–2004 *Annual Reports for ESRD Clinical Performance Measures Project* from CMS.

- The quality of dialysis care has improved on these measures. Between 2000 and 2003, the proportion of both hemodialysis and peritoneal patients receiving adequate dialysis and whose anemia was under control increased.

- Nutritional care is a clinical area in which substantial improvements in quality are needed. The proportion of hemodialysis and peritoneal dialysis patients who are malnourished has remained relatively constant during this time.

- All hemodialysis patients require vascular access—the site on the patient's body where blood is removed and returned during dialysis. Vascular access care is another clinical area in which substantial improvements in quality are needed. Use of arteriovenous (AV) fistulas, considered the best type of vascular access, increased from 30 percent to 35 percent of hemodialysis patients between 2000 and 2003. However, this rate still falls short of recommended care. Clinical guidelines recommend that at least 40 percent of all hemodialysis patients have an AV fistula.

Chart 4-9. Changes in safety of care for long-term care hospital patients, 2003–2004

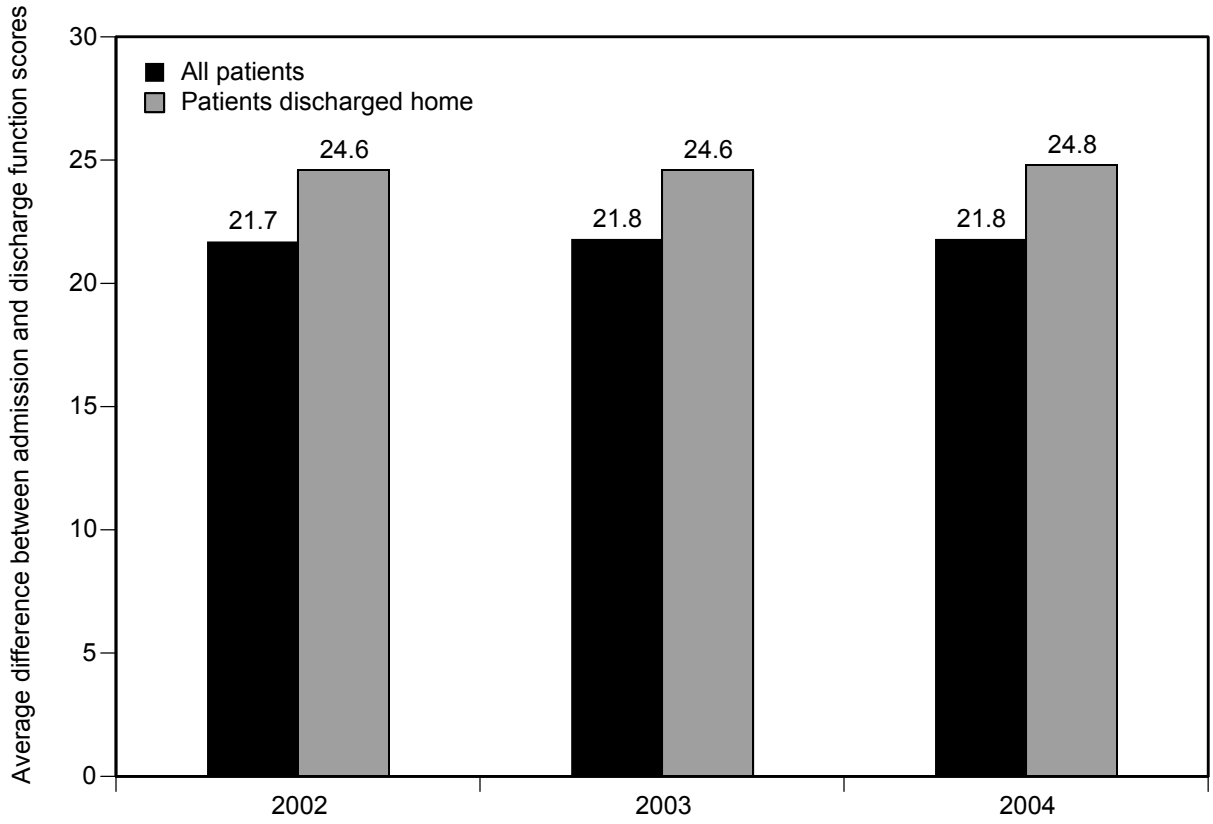
Patient safety indicator	Risk-adjusted rates per 1,000 eligible discharges			Observed adverse events 2004	Total number of patients
	2003	2004	Change in rate		
Decubitus ulcer	128.6	148.3	15%	14,624	94,368
Infection due to medical care	19.9	28.9	45	3,129	108,458
Postoperative PE or DVT	53.5	54.1	1	747	13,801
Postoperative sepsis	125.3	164.0	31	1,378	8,016

Note: PE (pulmonary embolism), DVT (deep vein thrombosis).

Source: MedPAC analysis of 100 percent of long-term care hospital MedPAR data from CMS.

- These rates suggest that for three of the four patient safety indicators (PSIs), safety for long-term care hospital (LTCH) patients has deteriorated. The rates for all four indicators increased from 2003 to 2004.
- Nevertheless, we need to be cautious about interpretation of the PSIs since they were not developed for LTCHs.
- We used selected PSIs developed by the Agency for Healthcare Research and Quality to assess potentially avoidable adverse events resulting in acute hospital care for patients treated in LTCHs in 2003 and 2004. These PSIs had enough observations for the two years and were thought to be relevant to the type of care LTCHs deliver.
- To distinguish patients who developed a PSI diagnosis in the LTCH, we included in the analysis only patients who did not have the pertinent diagnosis in the acute care hospital. Therefore, changes in these rates should not be a result of LTCHs admitting more patients who had these conditions in the acute care hospital.
- The PSIs are risk adjusted so these indicators should not reflect a changing LTCH patient population over time.

Chart 4-10. IRF patients' improvement in function has remained stable



Note: IRF (inpatient rehabilitation facility). CMS changed instructions on how IRFs should measure patients' functioning at discharge as of April 1, 2004; therefore, data reflect measurement before that date.

Source: MedPAC analysis of IRF–Patient Assessment Instrument data from CMS.

- Our indicators of the quality of care—average difference between admission and discharge function scores—provided by inpatient rehabilitation facilities shows small improvement from 2002 to 2004.

Chart 4-11. Medicare Advantage plans improve, but rates are still low on some measures, 2001–2004

Measure	2001	2002	2003	2004
Advising smokers to quit	60.8%	61.5%	63.3%	64.7%*
Beta-blocker treatment after heart attack	92.9	93.0	92.9	94.0
Breast cancer screening	75.3	74.5	74.0	74.0
Cholesterol management				
Control	58.4	62.3	66.7	69.8*
Screening	75.5	77.7	81.0	82.1*
Controlling high blood pressure	53.6	56.9	61.4	64.6*
Comprehensive diabetes care				
Eye exams[a]	66.0	68.4	64.9	67.1
HbA1c testing	85.7	85.0	87.9	89.1*
Lipid control	57.5	62.6	67.7	71.4*
Lipid profile	85.7	87.9	91.1	93.5*
Monitoring diabetic nephropathy	51.9	57.3[c]	53.6	58.5*
Poor HbA1c control[b]	26.8	24.5	23.4	22.5*
Antidepressant medication management[c]				
Acute phase	51.3	52.1	53.3	56.3*
Continuation phase	36.8	37.7	39.2	42.1*
Contacts	11.9	10.8	10.5	11.9
Follow-up after hospitalization for mental illness				
Less than 7 days	37.2	38.7	38.8	40.2
Less than 30 days	60.6	60.6	60.3	60.7

Note: HbA1c (hemoglobin A1c). Rates refer to patients for whom the treatments were clinically indicated.
* The changes between 2001 and 2004 on these indicators are statistically significant.
[a] The definition of these measures changed in 2003, making comparisons difficult.
[b] Lower rates are better than higher ones for this measure.
[c] Acute phase refers to the percent of patients receiving effective treatment after a new episode. Continuation refers to the percent of patients remaining on antidepressant continuously for six months after initial diagnosis. Contacts refers to the percent of patients who received at least 3 follow-up office visits in a 12-week acute phase.

Source: National Committee For Quality Assurance 2005, The State of Health Care Quality. Washington, DC: NCQA.

- Twelve out of the 17 measures improved between 2001 and 2004. Changes in four were not statistically significant and one remained at the same rate.
- Because many Medicare beneficiaries in Medicare Advantage plans are still not receiving clinically indicated services, opportunities for further improvement exist.

Chart 4-12. MA and FFS patient experience scores are similar

	MA			FFS		
Measure	2002	2003	2004	2002	2003	2004
No or small problem getting care when needed	93%	94%	95%	95%	95%	96%
Usually or always got care without long waits	81	83	83	81	84	83
Doctors in health plan usually or always communicate well	93	93	93	94	94	93
None or small problem seeing a specialist	92	92	93	95	95	94
Rated health care overall 8–10	84	84	84	85	86	86
Rated health plan 8–10	76	70	74	77	69	72

Note: MA (Medicare Advantage), FFS (fee-for-service). The ratings on the last two indicators show the percentage of beneficiaries who gave ratings of 8 or higher on a scale of 0 to 10.

Source: 2002–2004 Consumer Assessment of Healthcare Providers and Systems (CAHPS) data for Medicare Advantage plans and the fee-for-service program from CMS.

- Fee-for-service (FFS) beneficiaries were asked to rate Medicare as a health plan, while Medicare Advantage (MA) beneficiaries were asked to rate the plan in which they were enrolled.
- Beneficiaries' ratings of satisfaction with FFS and MA are generally similar and are stable over time.
- Most beneficiaries report obtaining care when they need it and do not report long waits.

Web links. Quality of care in the Medicare program

- Chapter 2 of the MedPAC June 2006 Report to the Congress discusses care coordination for Medicare beneficiaries and its implications for quality of care.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch02.pdf

- Chapter 2 of the MedPAC March 2006 Report to the Congress includes further information on quality in hospitals and outpatient dialysis services.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02.pdf

- Chapter 4 of the MedPAC March 2006 Report to the Congress includes further information on quality in skilled nursing facilities, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04.pdf

- Chapter 4 of the MedPAC March 2005 Report to the Congress outlines strategies to improve care through pay-for-performance incentives and information technology.

  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch04.pdf

- Chapter 2 of the MedPAC March 2004 Report to the Congress includes and discusses in further detail information similar to that included in many of these charts.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf

- The CMS website provides further information on CMS quality initiatives, including those for dialysis care.

  http://cms.hhs.gov/quality

- More information about Medicare's quality initiatives for dialysis care can be found on the CMS website.

  http://www.cms.hhs.gov/ESRDqualityImproveInit/

- Medicare provides information about home health agency outcomes on its consumer website.

  www.medicare.gov/Hhcompare/Home.asp

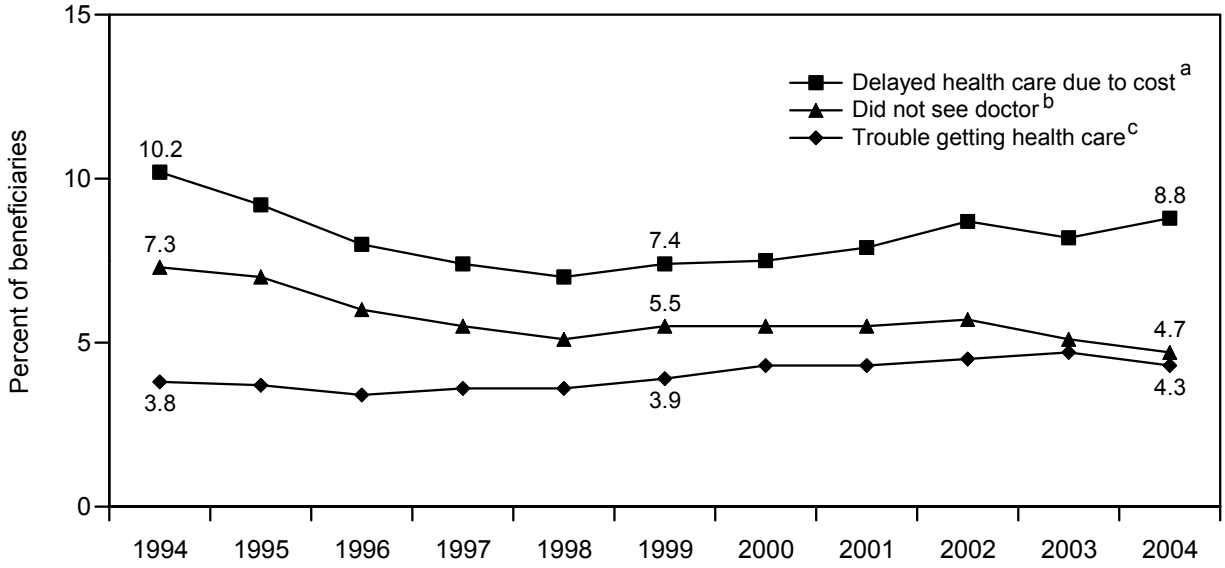
- The Commonwealth Fund published a chart book with information on Medicare quality in the spring of 2005.

  http://www.cmwf.org

SECTION 5

Access to care in the Medicare program

Chart 5-1. Beneficiaries' reports of difficulties obtaining care, 1994–2004



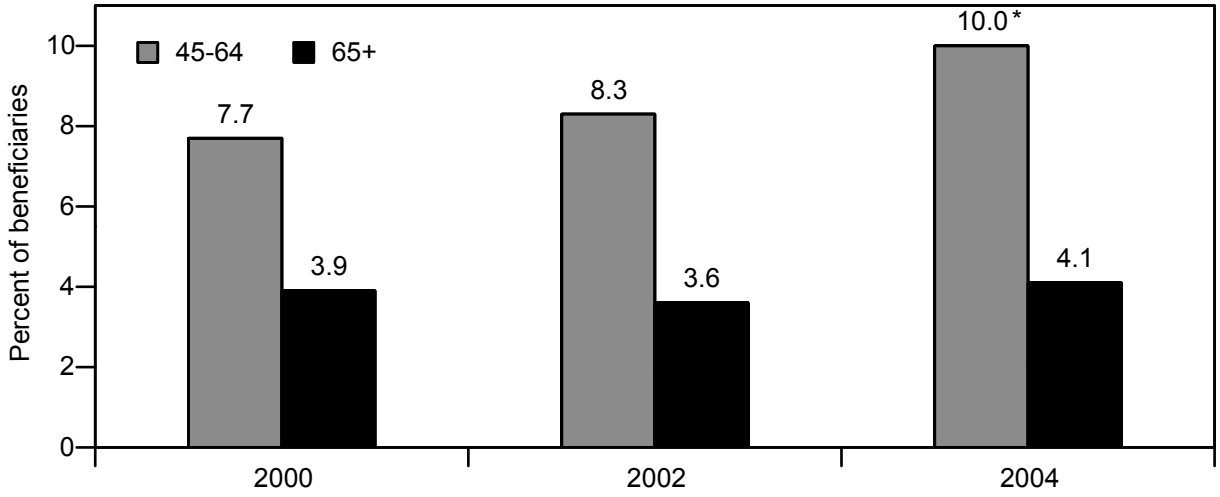
Note: These data reflect the answers given by noninstitutionalized beneficiaries.
[a] Answered "yes" when asked if they delayed seeking medical care because they were worried about the cost.
[b] Answered "yes" when asked if they had a serious health problem or condition about which they should have seen a doctor or other medical person, but did not.
[c] Answered "yes" when asked if they had any trouble getting health care that they wanted or needed.

Source: CMS analysis of Medicare Current Beneficiary Survey, Access to Care file, 2004.

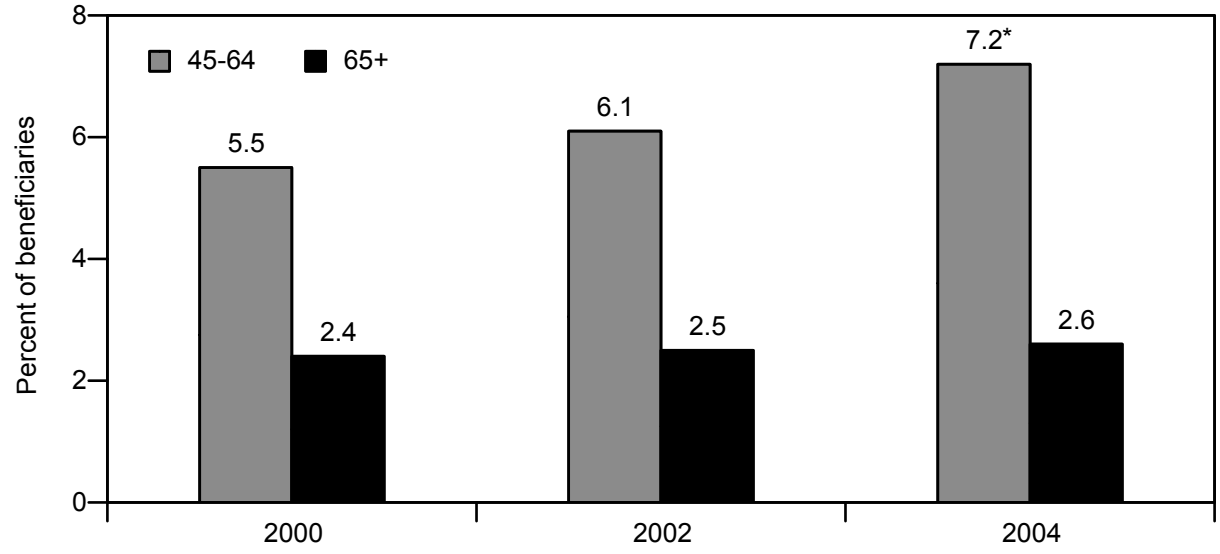
- In 2004, more than 90 percent of beneficiaries reported good access to care, regardless of the question asked.
- When asked whether they delayed health care due to cost, 8.8 percent of beneficiaries answered yes in 2004, compared to 10.2 percent in 1994.
- Similarly, the percentage reporting that they did not see a doctor (when they needed to) declined from 7.3 percent to 4.7 percent in 2004.
- The percentage of beneficiaries who reported trouble getting health care has remained relatively stable since 2000. However, since 1994, the beneficiaries who reported trouble getting health care increased from 3.8 percent to 4.3 percent in 2004.

Chart 5-2. Fewer aged beneficiaries delayed or failed to obtain care due to cost, compared with younger Americans

Delayed getting care due to cost



Failed to obtain care due to cost



Note: Medicare beneficiaries in the sample are over 65 years old and living in the community.
*Statistically significant change from 2000.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention: National Health Interview Survey, 2000, 2002, 2004.

- About 4 percent of persons over 65 years old delayed care and fewer than 3 percent failed to obtain care due to cost over the three time periods. These rates were much lower than problems reported by persons 45 to 64 years old. Changes in reported problems for Medicare beneficiaries are not statistically significant.

Chart 5-3. Access to physicians is similar for Medicare beneficiaries and privately insured people

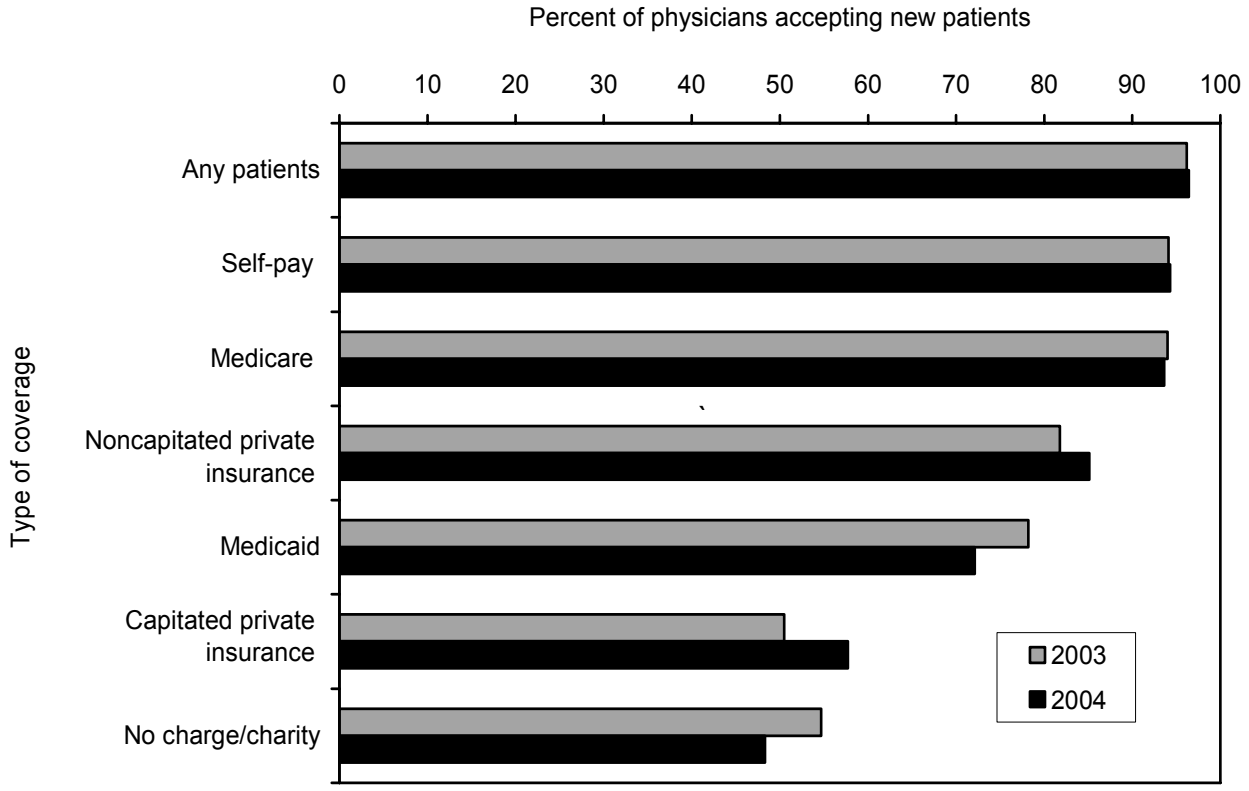
Survey question	Medicare Age 65 and older 2004	Medicare Age 65 and older 2005	Private insurance Age 50–64 2004	Private insurance Age 50–64 2005
Unwanted delay in getting an appointment: Among those who had an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"				
For routine care				
Never	73%*	74%*	66%*	67%*
Sometimes	21*	21	26*	25
Usually	4	3	5	5
Always	2	2	3	3
For illness or injury				
Never	83*	83*	77*	75*
Sometimes	13*	15	19*	19
Usually	2	1	3	3
Always	2	1	2	2
Getting a new physician: Among those who tried to get an appointment with a primary care physician or a specialist, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"				
Primary care physician				
No problem	77	75	73	75
Small problem	11	12	15	16
Big problem	11	13	13	9
Specialist				
No problem	89	89	83	86
Small problem	5	6	8	7
Big problem	5	5	8	6
Not accessing a doctor for medical problems: "In the past year, do you think you should have seen a doctor for a medical problem, but did not?"	6*	7*	11*	12*

Note: Numbers may not sum to 100 percent due to rounding. Missing responses are not presented. For the 2004 survey, n=4,122 (2,087 Medicare; 2,035 privately insured); for the 2005 survey n=4,021 (2,012 Medicare; 2,009 privately insured). For each survey question, there is no statistical difference between years, at a 95 percent confidence level.
*Indicates a statistically significant difference between the Medicare and privately insured populations, at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys conducted August–September 2004 and 2005.

- Medicare beneficiaries and privately insured people age 50 to 64 reported very similar experiences accessing physicians. For some indicators, Medicare beneficiaries enjoyed slightly better access than their privately insured counterparts.
- Most Medicare beneficiaries and people age 50 to 64 did not have a delay getting an appointment due to scheduling issues. For both groups, appointment scheduling was easier for illness or injury appointments than for routine care.
- Both Medicare beneficiaries and privately insured individuals reported more difficulty finding a primary care physician than a specialist, but most were able to access either type with little or no problem.
- In 2005, 7 percent of Medicare beneficiaries and 12 percent of privately insured individuals said they think they should have seen a doctor for a medical problem in the past year, but did not. Respondents indicated that physician availability issues (e.g., appointment time, finding a doctor) were less common reasons for not seeing a doctor than other reasons, such as cost.

Chart 5-4. Percent of physicians accepting new patients, by type of insurance, 2003–2004



Note: Estimates include only physicians for whom at least 10 percent of their revenues come from Medicare. Office-based physicians exclude the specialties of anesthesiology, radiology, and pathology.

Source: Unpublished data from the National Ambulatory Medical Care Survey, 2003–2004.

- The share of physicians accepting new Medicare fee-for-service patients remained high in 2003 and 2004—above 90 percent.
- Although acceptance of capitated private insurance is lower than noncapitated private insurance, physician acceptance of both increased a little between 2003 and 2004.
- Specialists and surgeons are more likely to accept new Medicare patients than primary care physicians. The share of primary care physicians who accept new patients declined slightly, at about the same rate for both Medicare and privately insured patients between 1999 and 2002 (not shown in table).

Chart 5-5. Physician acceptance of new Medicare patients has stabilized

Patients	Percentage of physicians accepting new patients		
	1996–1997	2001–2002	2004–2005
New Medicare			
All	75%	71%*	73%
Most	13	15*	14
Some	10	10	10
None	3	4*	3
New privately insured			
All	71	68*	72**
Most	16	17	15
Some	10	10	9
None	4	5*	4

Note: Medicare rates exclude pediatricians, pediatric specialists, nephrologists, and physicians accepting no new privately insured patients.
*Change from 1996–1997 is statistically significant at p<.05.
**Change from 2000–2001 is statistically significant at p<.05.

Source: Cunningham, P., A. Staiti, and P. B. Ginsburg. 2006. *Physician acceptance of new Medicare patients stabilizes in 2004–05*. Tracking report no. 12. Washington, DC: Center for Studying Health System Change. January.

- The large majority of physicians in the United States are willing to accept new Medicare beneficiaries, and this share remains steady, according to survey findings from The Center for Studying Health System Change (HSC).

- Only 3 percent of physicians with practices open to private patients completely closed their practice to new Medicare patients. In contrast, 73 percent of physicians with practices open to private patients reported that they accepted all new Medicare patients; 14 percent said they accepted most new Medicare patients; and 10 percent said they accepted some new Medicare patients.

- While there was a dip in acceptance of Medicare patients between 1996–1997 and 2000–2001, the study authors suggest that the increases in the most recent survey (2004–2005) indicate stabilization.

- Physician acceptance of new Medicare patients follows a similar trend as acceptance of new privately insured patients, suggesting that overall health system dynamics have played a larger role in physician decisions about accepting Medicare patients than have Medicare payment policies.

Chart 5-6. Most beneficiaries had little or no problem accessing home health and special therapy services

	Home health				Special therapy			
	2001	2002	2003	2004	2001	2002	2003	2004
Did you experience a problem?								
No problem	74%	76%	77%	78%*	84%	85%	85%	85%*
A small problem	13	13	12	12*	9	8	8	8*
A big problem	12	12	11	11*	7	7	6	6

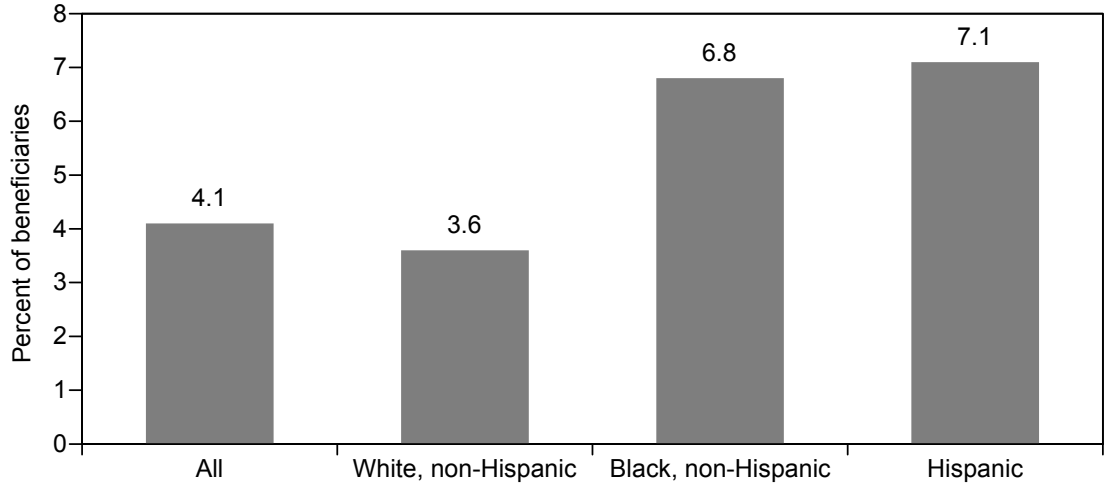
Note: Percentages are proportions of those who answered the question. Missing responses were not included. Columns do not total 100 percent due to rounding.
*The difference between 2001 and 2004 is significant at the p<.05 level.

Source: MedPAC analysis of Consumer Assessment of Health Plans Survey, 2001–2004.

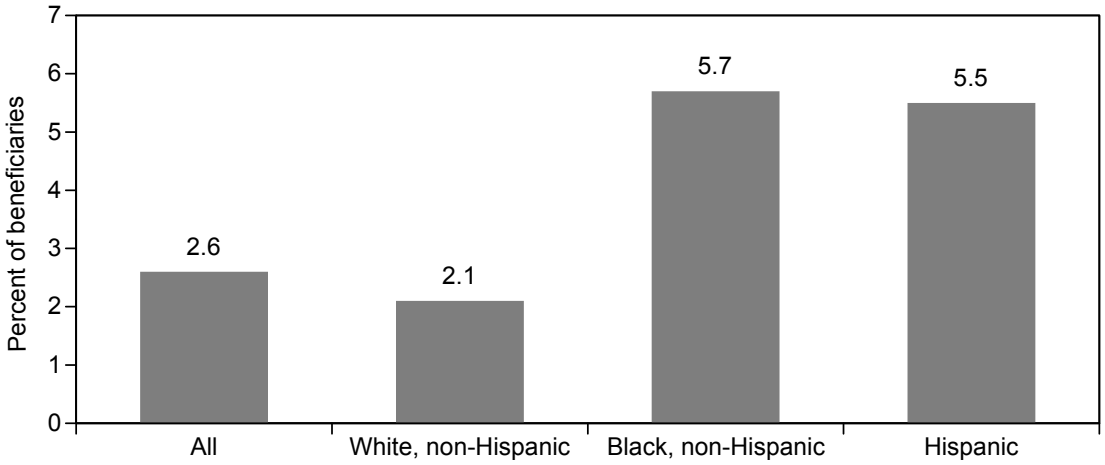
- Most beneficiaries had little or no problem accessing home health services (90 percent) and special therapy services (93 percent—which includes physical and occupational therapies and speech-language pathology services).
- In 2004, 78 percent of beneficiaries reported having no problems accessing home health services, a slight increase over the share in 2001.
- In 2004, 85 percent of beneficiaries reported having no problems accessing special therapy services, a slight increase over the share in 2001.

Chart 5-7. Ethnic and racial disparities in delaying or failing to obtain care, 2004

Delayed getting care due to cost



Failed to obtain care due to cost



Note: Beneficiaries in the sample are over 65 years old and living in the community.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention: National Health Interview Survey, 2004.

- Few persons over 65, regardless of race or ethnicity, report delaying or failing to obtain care.
- Hispanics were more likely to report problems and white, non-Hispanics were least likely to report problems.

Chart 5-8. Beneficiaries differ in their reports of obtaining needed, urgent, or routine care, 2004

Beneficiary characteristic	No problem getting needed care	Always got care as soon as wanted	
		Urgent	Routine
Overall	90%	73%	63%
Aged (65 years and older)	92	76	64
Disabled (Under 65)	83	63	56
White	92	75	64
African American	85	68	63
Hispanic	81	61	55
Medicare only	84	66	61
Dually eligible	81	67	59
Supplemental Insurance	93	76	64

Source: Research Triangle Institute analysis of data from the Medicare Fee-for-Service National Implementation Subgroup Analysis 2004, submitted to CMS.

- The percentage of beneficiaries reporting no problem getting needed care is significantly higher than those who reported that they could get urgent or routine care as soon as they wanted it. This may seem inconsistent, but the last two questions add the dimension of timing into their responses. It appears that while most beneficiaries are able to get care, they may not get it as soon as they want it.

- Disabled beneficiaries under 65 were more likely than aged beneficiaries to report problems receiving necessary, urgent, or routine care.

- The presence and type of supplemental insurance also affected beneficiaries' ability to obtain care with no problems. Sixty-seven percent of dually eligible beneficiaries reported they always got urgent care as soon as they wanted, compared with 73 percent of all beneficiaries. Seventy-six percent of beneficiaries with supplemental insurance reported the same experience.

- Hispanics had a harder time than other ethnic or racial groups getting needed, urgent, and routine care.

Web links. Access to care in the Medicare program

- Chapter 2B of the MedPAC March 2006 Report to the Congress provides more information on beneficiary access to physicians.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02b.pdf

- Chapter 3 of the MedPAC March 2003 Report to the Congress provides a broad overview about beneficiary access to health care.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch3.pdf

- The Commonwealth Fund released a chart book in Spring 2005 which has further information on access in the Medicare program.

  http://www.cmwf.org

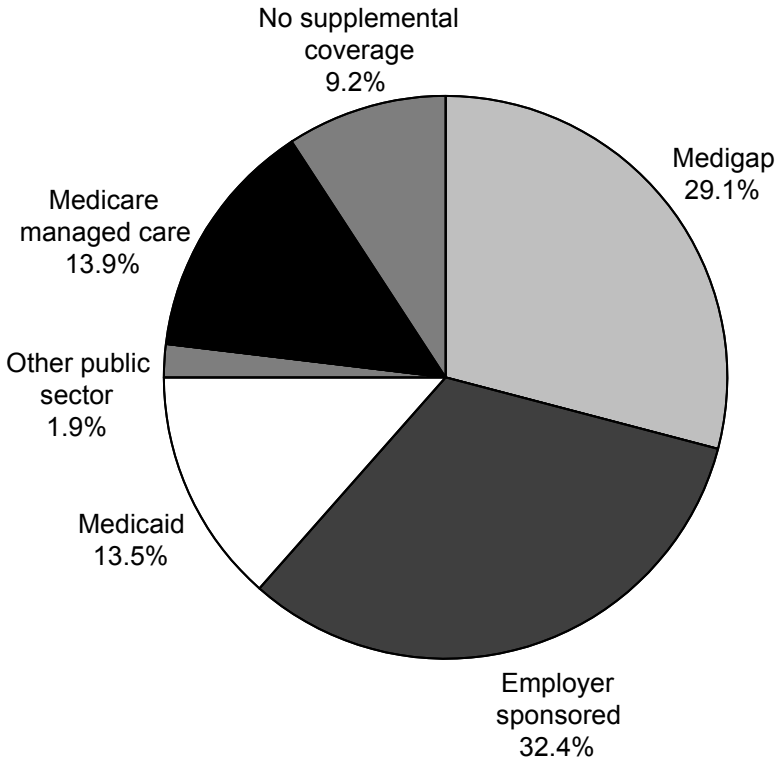
- Additional information about physician acceptance of new Medicare patients can be found at

  http://www.hschange.org/CONTENT/811/

SECTION 6

Medicare beneficiary and other payer financial liability

Chart 6-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2003



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2003. They could have had coverage in other categories throughout 2003. Other public sector includes federal and state programs not included in other categories. Analysis includes only beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2003 or who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. Ninety-one percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- Sixty-one percent have private-sector supplemental coverage such as Medigap (29 percent) or employer-sponsored retiree coverage (32 percent).
- Fifteen percent have public-sector supplemental coverage, primarily Medicaid.
- Fourteen percent participate in Medicare managed care. This includes Medicare+Choice (now Medicare Advantage), cost, and health care prepayment plans. These types of arrangements generally replace Medicare coverage and often add to it.

Chart 6-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2003

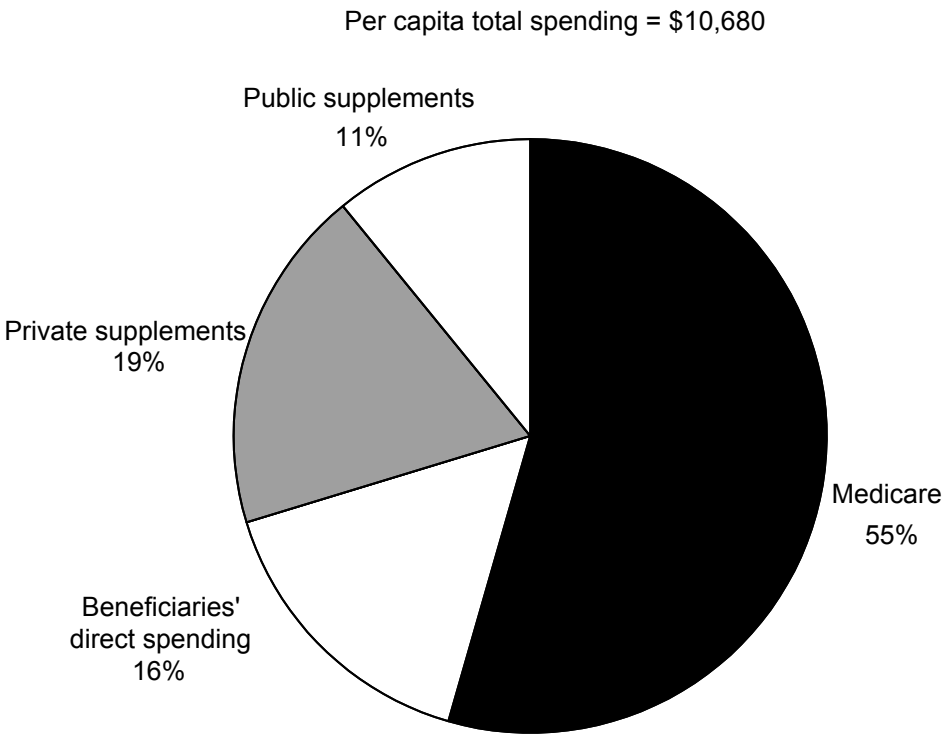
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**36,154**	**32.4%**	**29.1%**	**13.5%**	**13.9%**	**1.9%**	**9.2%**
Age							
< 65	4,686	15.2	6.1	46.2	7.6	2.9	22.0
65–69	8,202	39.0	27.7	9.5	12.7	1.9	9.3
70–74	7,702	37.1	30.1	8.1	15.6	1.6	7.6
75–79	6,926	31.9	34.6	8.5	17.2	2.1	5.8
80–84	4,893	33.2	37.1	8.0	13.9	1.7	6.1
85+	3,745	29.3	38.5	9.2	15.1	1.4	6.5
Income status							
Below poverty	5,781	11.5	13.3	53.0	8.7	2.3	11.3
100–125% of poverty	3,451	15.6	26.8	28.1	14.2	3.2	12.2
125–200% of poverty	8,197	26.0	31.5	8.3	16.5	3.5	14.2
200–400% of poverty	10,338	41.8	32.4	1.0	15.5	1.2	8.1
Over 400% of poverty	8,355	48.5	34.7	0.5	12.8	0.6	2.9
Eligibility status							
Aged	31,298	34.9	32.6	8.6	14.8	1.8	7.2
Disabled	4,541	15.0	6.3	45.7	7.8	3.0	22.3
ESRD	289	32.4	9.6	39.7	7.5	1.0	9.8
Residence							
Urban	27,499	33.4	26.8	12.4	17.6	1.9	8.0
Rural	8,639	29.0	36.6	17.0	2.2	2.1	13.0
Sex							
Male	15,947	34.7	25.7	11.9	13.1	2.1	12.5
Female	20,207	30.5	31.8	14.8	14.6	1.8	6.6
Health status							
Excellent/very good	14,697	35.4	33.5	6.5	15.6	1.3	7.7
Good/fair	18,188	31.6	27.7	16.1	13.1	2.4	9.1
Poor	3,056	22.3	16.0	32.5	10.5	2.4	16.3

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2003. They could have had coverage in other categories throughout 2003. Medicare managed care includes Medicare+Choice, cost, and health care prepayment plans. Other public sector includes federal and state programs not included in other categories. In 2003, poverty was defined as $8,825 for people living alone and as $11,133 for married couples. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes only beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2003 or had Medicare as a second payer. In previous editions of the Data Book, this analysis was based on beneficiaries only in Part A or Part B.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are age 65 to 84, higher income (above 200 percent of poverty), eligible due to age or end-stage renal disease (ESRD), urban dwelling, and male, and who report excellent or very good health.
- Medigap is most common among those who are "older" aged (age 80 or older), middle or high income (above 125 percent of poverty), eligible due to age, rural dwelling, female, and who report excellent or very good health.
- Medicaid coverage is most common among those who are under 65, low income (below 125 percent of poverty), eligible due to disability or ESRD, rural dwelling, female, and who report poor health.
- Medicare managed care is most common among those who are age 65 or older, have incomes between 125 and 400 percent of poverty, are eligible due to age, are urban dwelling, and report excellent or very good health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, with income below 200 percent of poverty, eligible due to disability, rural dwelling, male, and who report poor health.

Chart 6-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2003



Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Analysis includes only FFS beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

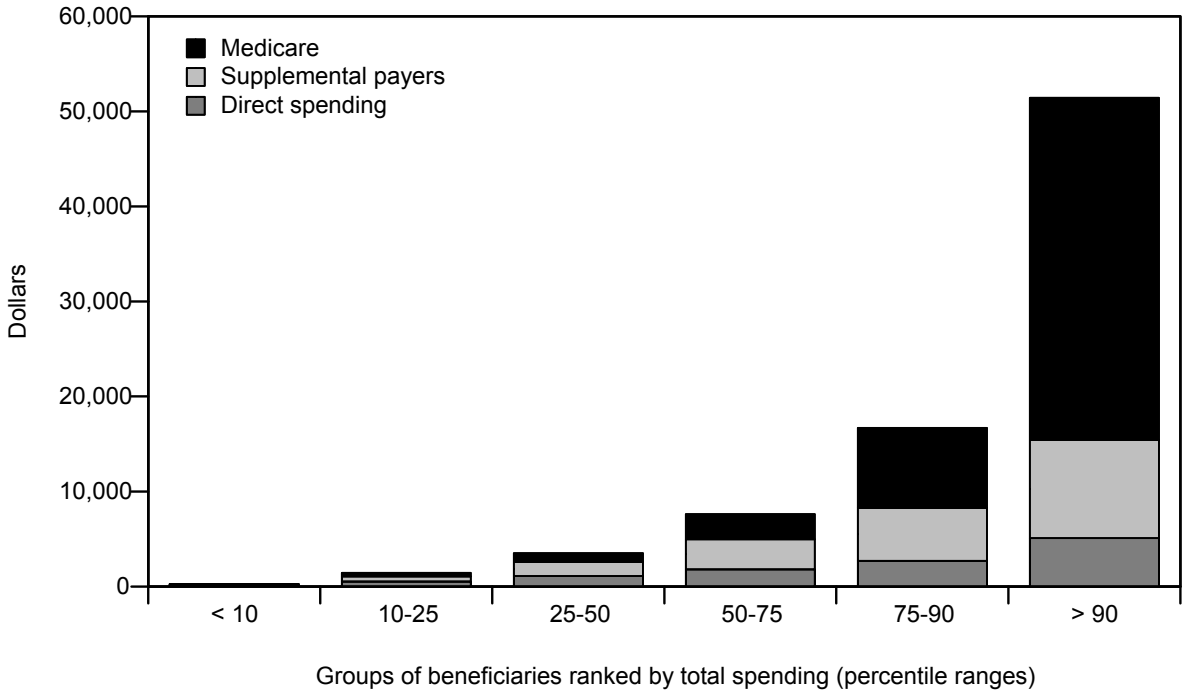
- Among fee-for-service (FFS) beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' direct spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averages $10,680. Medicare is the largest source of payment; it pays 55 percent of the health care costs for FFS beneficiaries living in the community, or an average of $5,822 per beneficiary.

- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—pay 19 percent of beneficiaries' costs, or an average of $1,985 per beneficiary.

- Beneficiaries pay 16 percent of their health care costs out of pocket, with an average of $1,742 of spending per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—pay 11 percent of beneficiaries' health care costs, or an average of $1,130 per beneficiary.

Chart 6-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2003



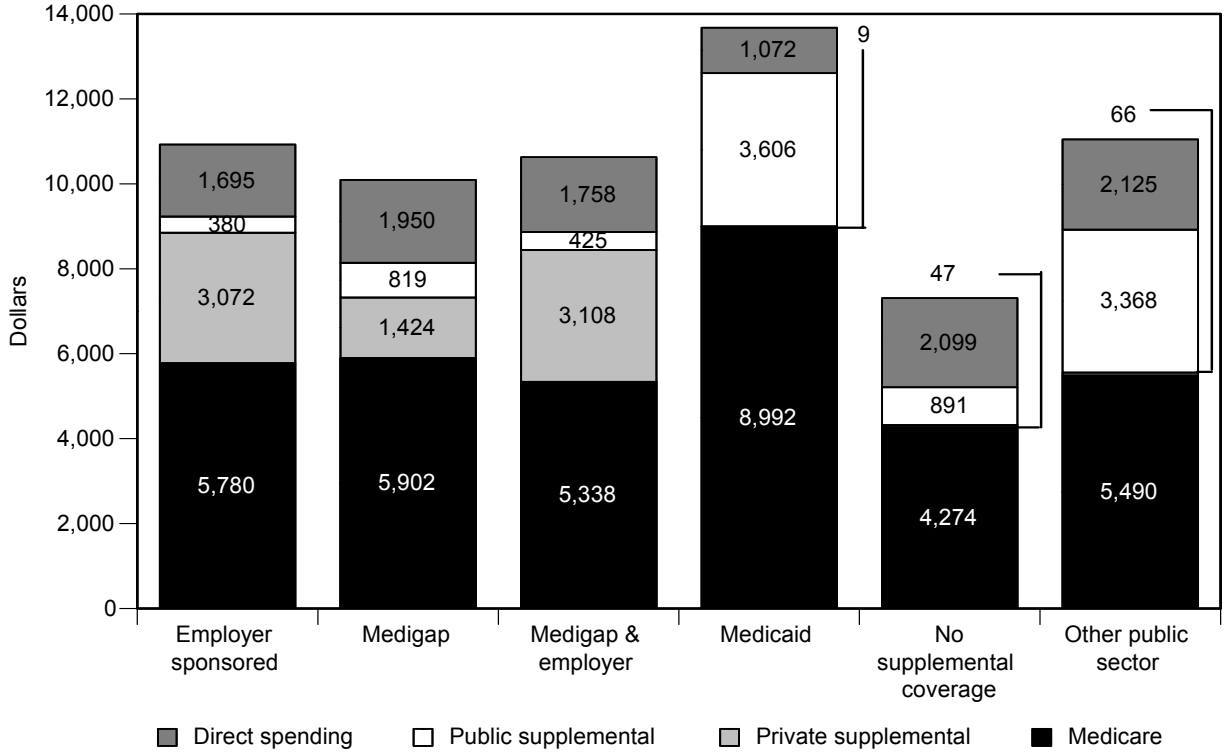
Note: FFS (fee-for-service). Analysis includes fee-for-service beneficiaries living in the community. Direct spending is on Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- Total spending on health care services varies dramatically among fee-for-service (FFS) beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averages $51,400. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averages $271.

- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' direct spending is a smaller percentage as total spending increases. For example, Medicare pays 55 percent of total spending for all beneficiaries, but 70 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' direct spending covers 16 percent of total spending for all beneficiaries, but only 10 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 6-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2003



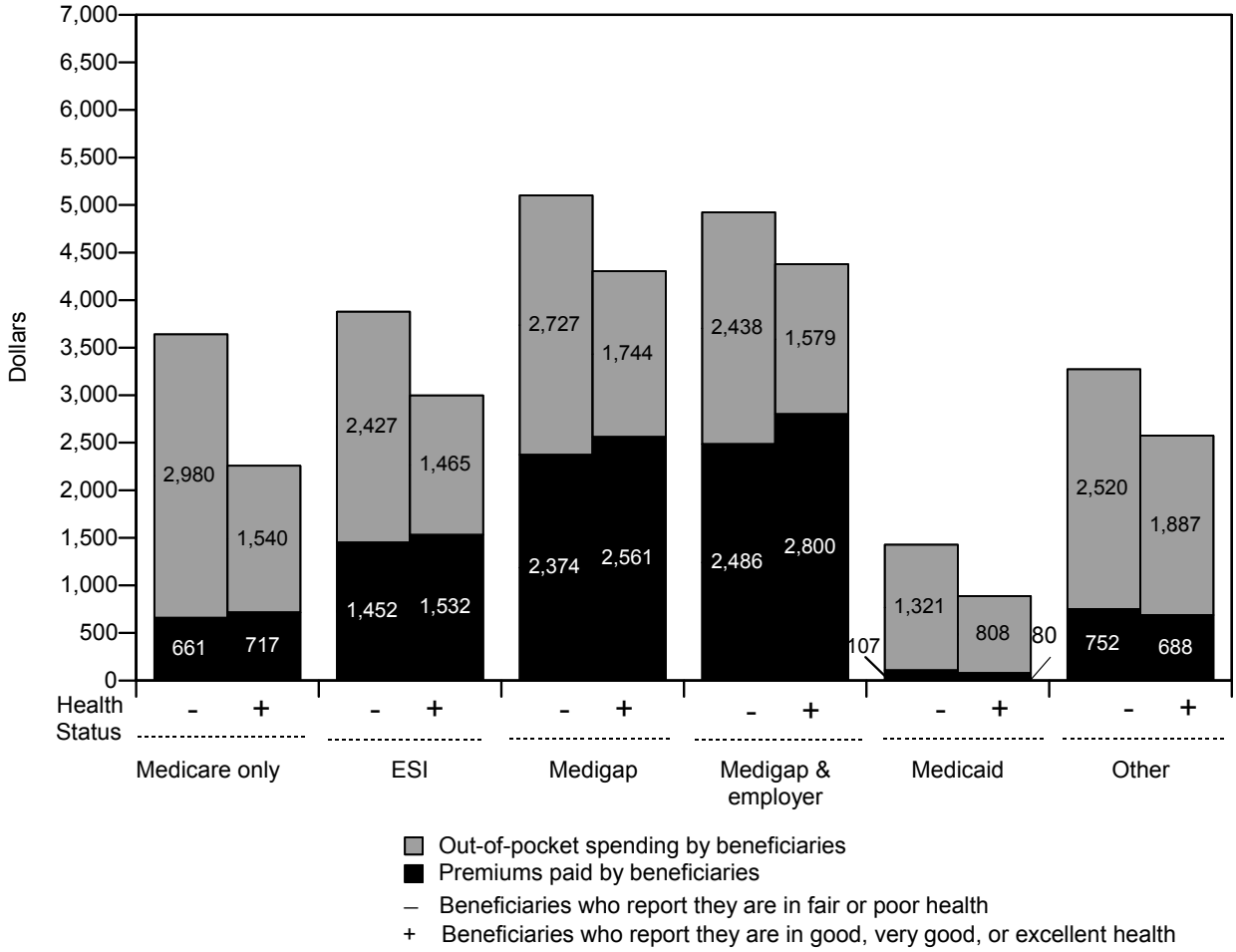
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2003. They could have had coverage in other categories throughout 2003. Other public sector includes federal and state programs not included in the other categories. Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Analysis includes only FFS beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2003 or had Medicare as a second payer. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2003.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among fee-for-service beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 87 percent higher than those with no supplemental coverage.

- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with supplemental coverage, that coverage—public and private combined—is the second largest source of payment. However, among those with Medicare only, beneficiaries' direct spending is the second largest source of payment.

Chart 6-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2003



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use File, 2003.

- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare.

- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with Medigap, out-of-pocket spending generally reflects the premiums and costs of prescription drugs and other services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for prescription drugs than those with Medigap, but may pay more in Medicare deductibles and cost sharing.

- Reductions in coverage and benefits offered under ESI plans, changes to Medicare benefits, and increases in premiums for all supplemental insurance since 2003 are not reflected in these data.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC 2006 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/publications/congressional _reports/Mar06_Ch01.pdf

- Chapter 1 of the MedPAC March 2005 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch01.pdf

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

  http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

  http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

- Chapter 1 of the MedPAC March 2004 Report to the Congress provides more information on beneficiary and Medicare program spending as well as information about supplemental insurance.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf

- Chapter 1 of the MedPAC March 2003 Report to the Congress provides more information on beneficiary and program spending.

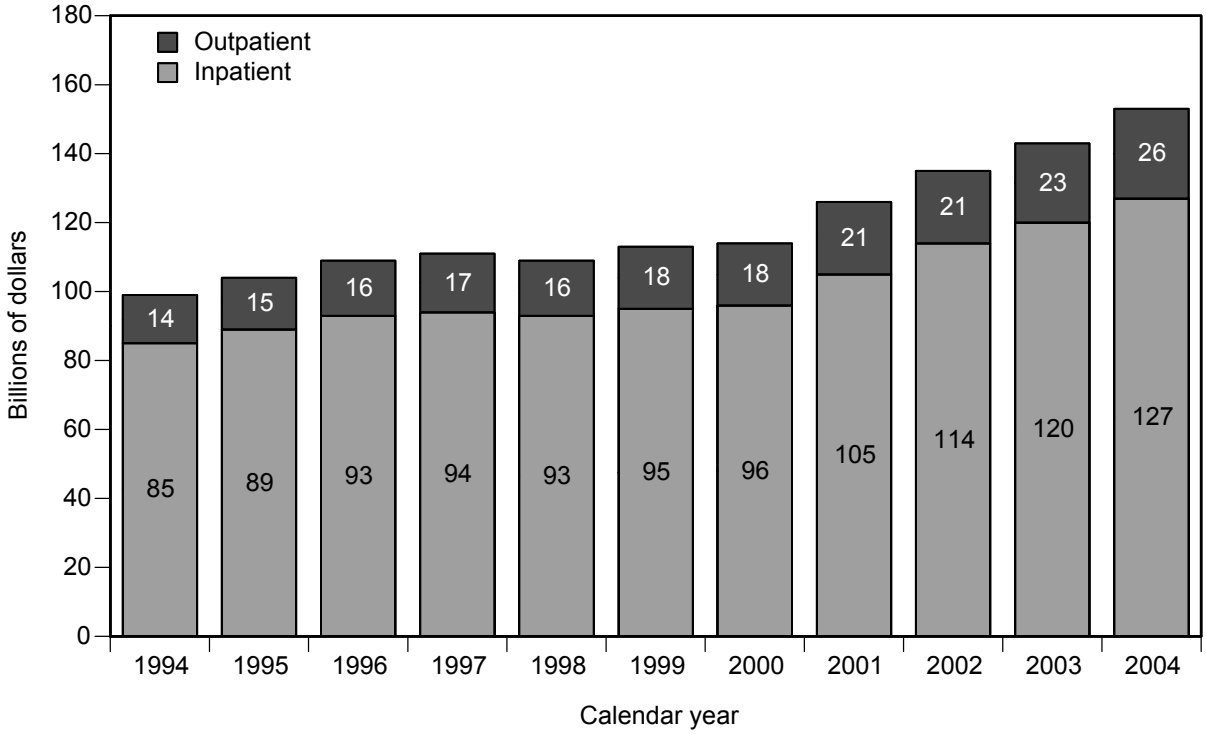
  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch1.pdf

SECTION 7

Acute inpatient services

Short-term hospitals
Specialty psychiatric facilities

Chart 7-1. Growth in Medicare's payments for hospital inpatient and outpatient services continues, 1994–2004



Notes: Analysis includes inpatient services covered by the acute inpatient prospective payment system (PPS); psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; outpatient services covered by the outpatient PPS; and other outpatient services. Payments include both program outlays and cost sharing incurred by beneficiaries.

Source: CMS, Office of the Actuary.

- Medicare hospital inpatient spending increased 50 percent (4.1 percent per year) and outpatient spending 91 percent (6.7 percent per year) from 1994 to 2004.

- A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA), combined with lower Medicare discharges, reduced inpatient spending in 1998. Higher Medicare discharges, a higher update, case-mix change, and expansion of disproportionate share hospital payments increased inpatient spending in 2001 and 2002. In 2003 and 2004, slower Medicare discharge growth, slower case-mix change, and lower outlier spending led to slight moderation in inpatient spending growth.

- Outpatient spending fell in 1998, reflecting the BBA's elimination of inadvertent overpayments. Transitional corridor and new technology payments in the outpatient prospective payment system, along with volume increase, increased outpatient spending in 2001 and 2002. Slower volume growth and changes in pass-through payments led to slower expenditure growth in 2003. Payment for certain outpatient drugs on an average wholesale price basis increased payments in 2004.

- Aggregate Medicare inpatient spending was $127 billion and outpatient spending was $26 billion in 2004.

Chart 7-2. Diagnosis related groups with highest volume, fiscal year 2004

DRG number	DRG name	Percentage of discharges	Percentage of payments
127	Heart failure and shock	6%	4%
89	Simple pneumonia and pleurisy age >17 with CC	5	3
209	Major joint and limb reattachment procedures of lower extremity	4	5
88	Chronic obstructive pulmonary disease	3	2
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 with CC	2	1
174	GI hemorrhage with CC	2	1
296	Nutritional and miscellaneous metabolic disorders age >17 with CC	2	1
143	Chest pain	2	1
416	Septicemia age >17	2	2
14	Intracranial hemorrhage or stroke with infarct	2	2

Note: DRG (diagnosis related group), CC (complication or comorbidity), GI (gastrointestinal).

Source: MedPAC analysis of MedPAR data from CMS.

- In fiscal year 2004, 10 diagnosis related groups (DRGs) accounted for 30 percent of discharges and 21 percent of payments at hospitals paid under the acute inpatient prospective payment system.
- In fiscal year 2006, Medicare inpatient cases are assigned to 524 DRGs based on discharge diagnoses, procedures performed, age, sex, discharge destination, and presence of complications or comorbidities.

Chart 7-3. Number of acute care hospitals and Medicare discharges, by hospital group, 2004

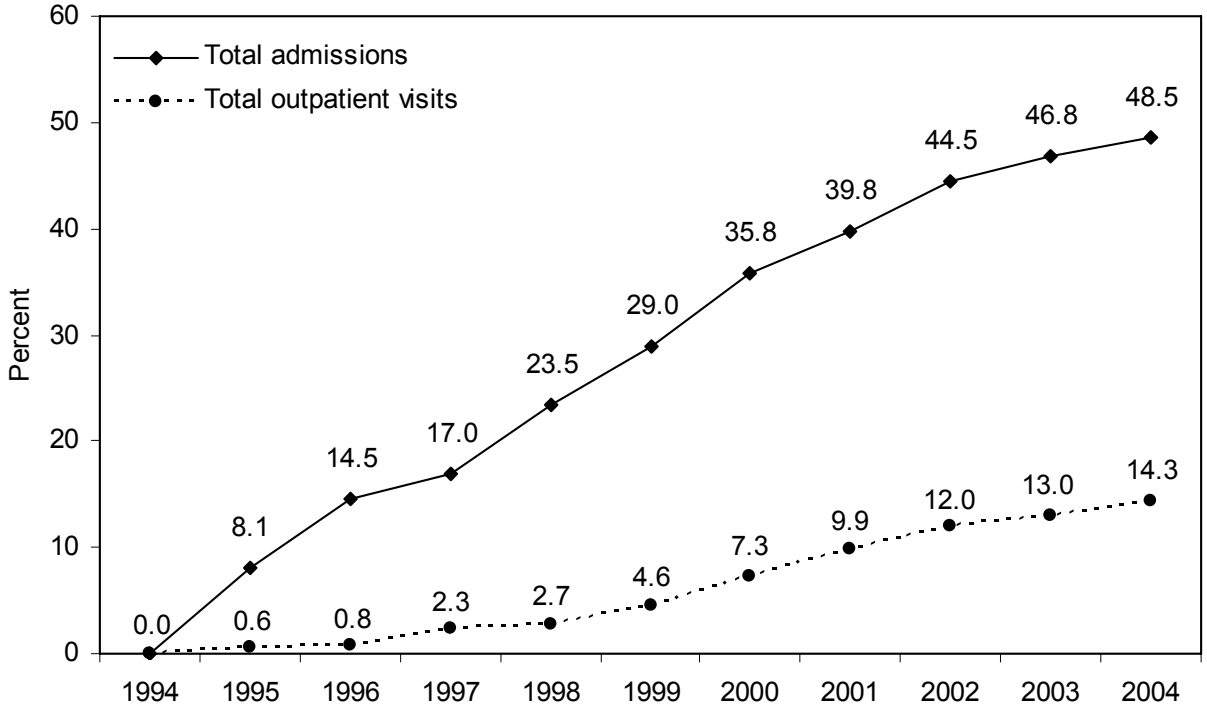
	Hospitals		Medicare discharges	
Hospital group	Number	Share of total	Number (thousands)	Share of total
All PPS and critical access hospitals	4,450	100.0%	12,741	100.0%
PPS hospitals	3,575	80.3	11,501	90.3
Urban	2,482	55.8	9,694	76.1
Rural	1,093	24.6	1,807	14.2
Large urban	1,373	30.9	5,288	41.5
Other urban	1,109	24.9	4,405	34.6
Rural referral	137	3.1	486	3.8
Sole community	450	10.1	707	5.5
Small rural Medicare-dependent	165	3.7	178	1.4
Other rural <50 beds	132	3.0	94	0.7
Other rural ≥50 beds	209	4.7	342	2.7
Voluntary	2,147	48.2	8,280	65.0
Proprietary	770	17.3	1,800	14.1
Government	652	14.7	1,418	11.1
Major teaching	297	6.7	1,734	13.6
Other teaching	783	17.6	3,980	31.2
Nonteaching	2,495	56.1	5,787	45.4
Critical access hospitals	875	19.7%	1,241	9.7%

Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least .25. Other teaching hospitals have a ratio of below .25.

Source: MedPAC analysis of impact file and Medicare cost report data (August 2004) from CMS.

- In 2004, 3,575 hospitals provided 11.5 million discharges under Medicare's acute inpatient PPS and 875 critical access hospitals provided another 1.2 million discharges.
- About 17 percent of acute care hospitals (21 percent of PPS hospitals) are covered by special payment provisions intended to help rural facilities that do not become critical access hospitals (rural referral, sole community, and small rural Medicare-dependent hospitals); these facilities provide 11 percent of all discharges.
- See Chart 7-26 for more information about critical access hospitals.

Chart 7-4. Cumulative change in total admissions and total outpatient visits, 1994–2004



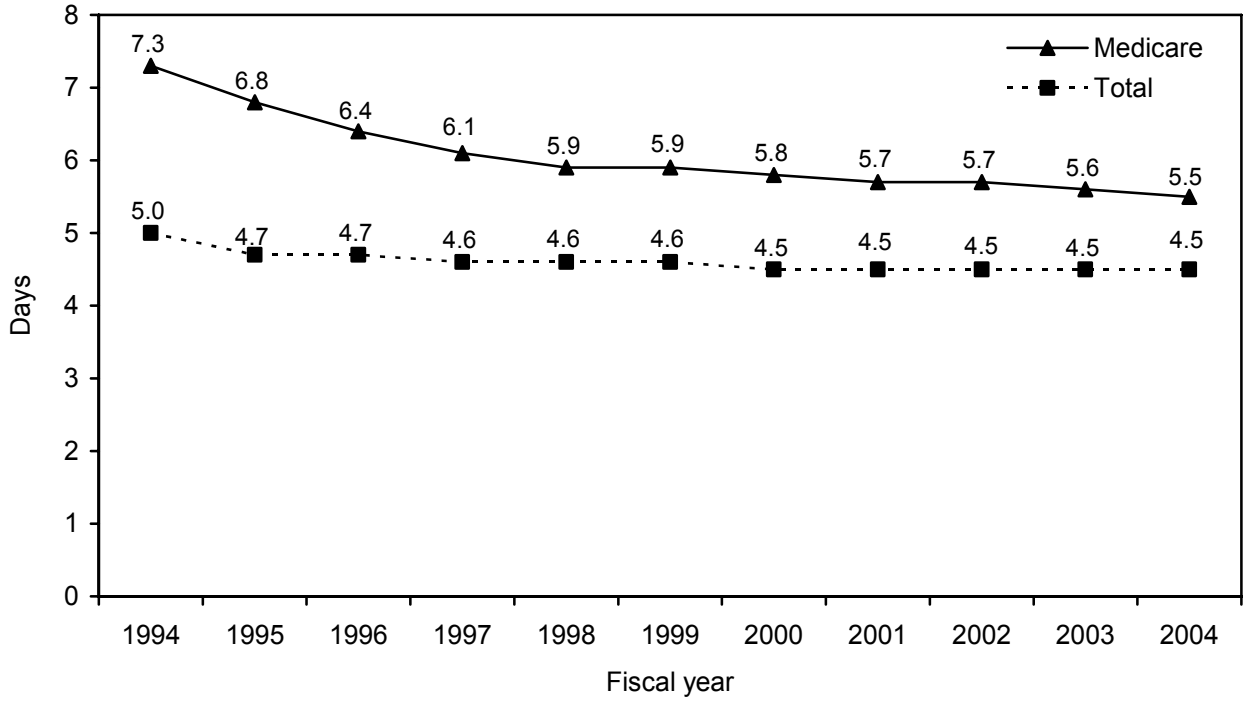
Note: Cumulative change is the total percent increase from 1994 through the year indicated. Data are admissions to and outpatient visits at approximately 5,000 community hospitals, excluding nursing home units.

Source: American Hospital Association Annual Survey of Hospitals.

- Hospital outpatient service use has grown much more rapidly than inpatient service use. Total hospital outpatient visits increased 49 percent from 1994 to 2004, while total admissions grew just 14 percent.

- There were 577 million outpatient visits and 35 million admissions to community hospitals in 2004.

Chart 7-5. Trends in Medicare and total hospital length of stay, 1994–2004



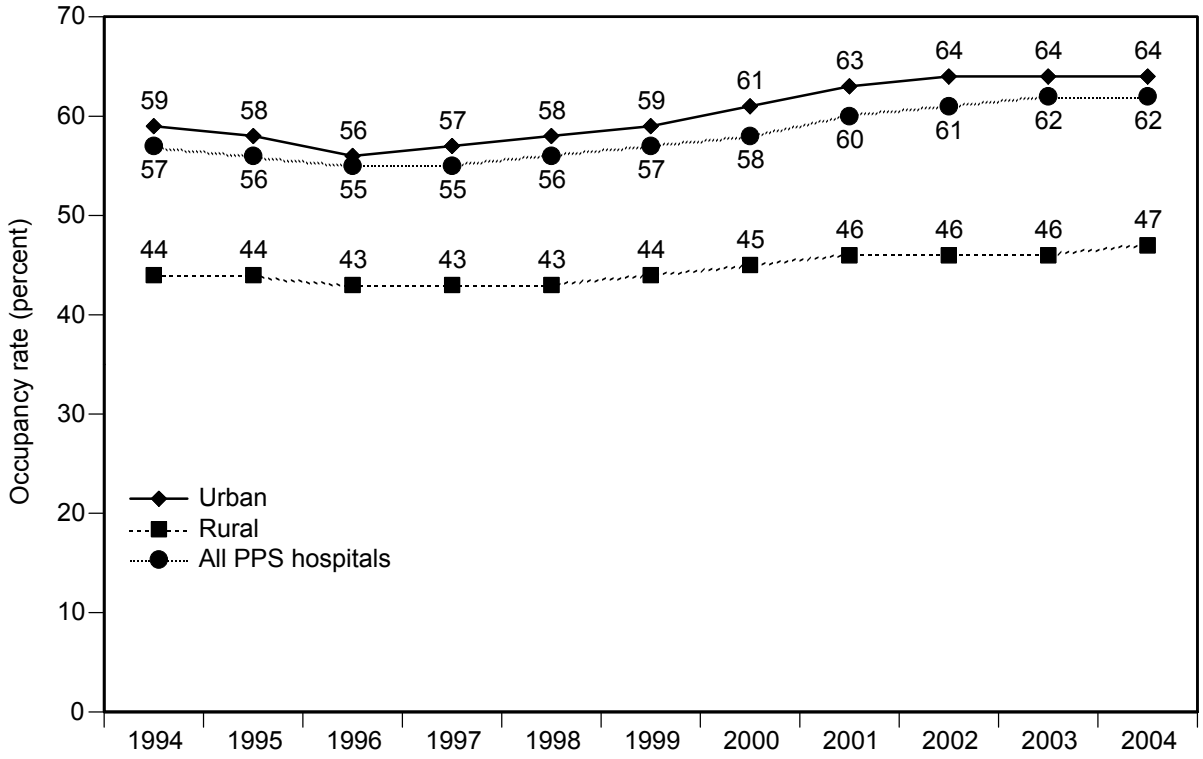
Note: Length of stay is calculated from discharges and patient days for approximately 3,600 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Length of stay for all hospital discharges fell 11 percent from 5.0 days in 1994 to 4.5 days in 2004, dropping at an average annual rate of 2.6 percent from 1994 to 1997 and 0.6 percent from 1997 to 2004.

- Length of stay for Medicare inpatients fell 25 percent from 7.3 days in 1994 to 5.5 days in 2004, dropping at an average annual rate of 5.8 percent from 1994 to 1997 and 1.5 percent from 1997 to 2004.

Chart 7-6. Hospital occupancy rates, 1994–2004

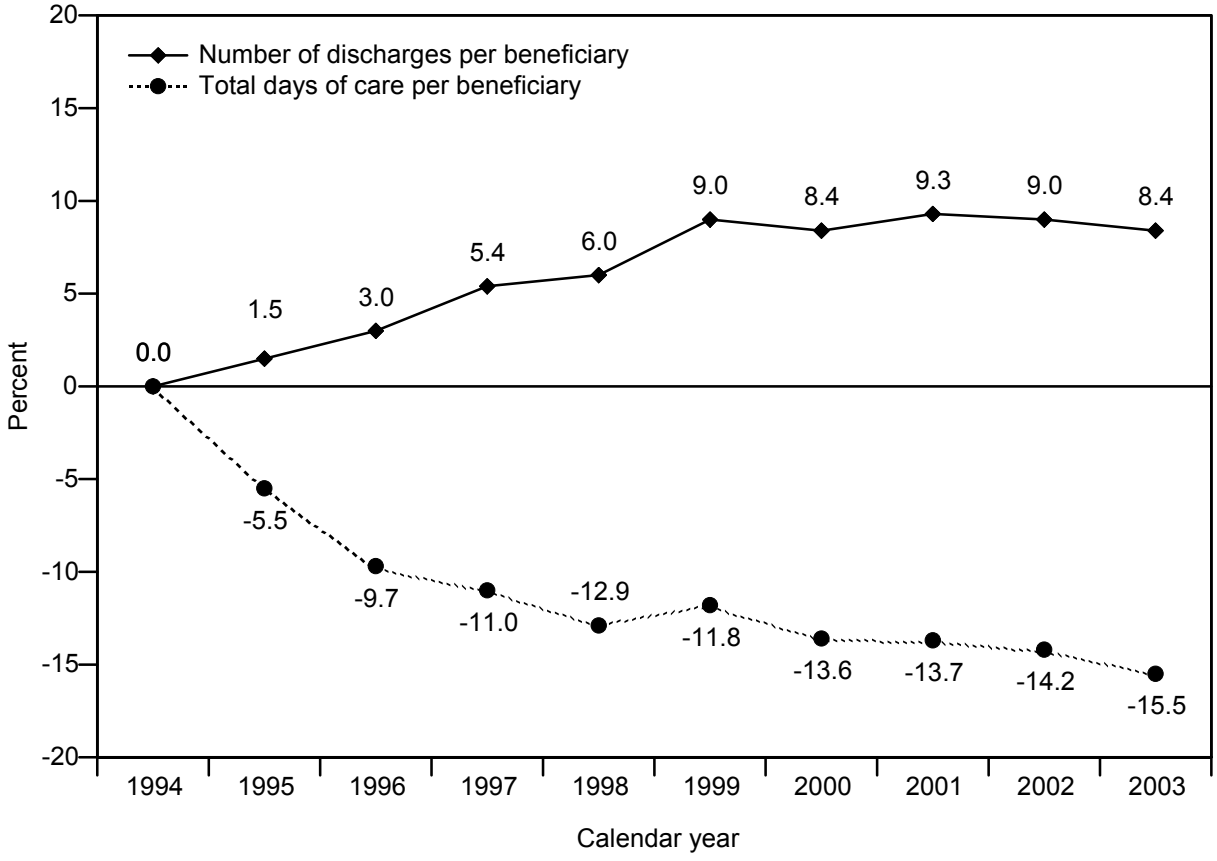


Note: PPS (prospective payment system). Hospital occupancy rate is measured as total inpatient days as a percent of total available bed days in the hospital over the cost reporting period. Theoretically, bed days available are staffed beds that are available for inpatient service (i.e., the units are open and operating), but the beds may not be staffed for a full patient load in that unit on any given day. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Hospitals' occupancy rates have been rising since 1996, with the aggregate occupancy rate climbing from 55 percent in 1996 to 62 percent in 2004.
- Occupancy rates in aggregate are much higher in urban than rural hospitals; in 2004, occupancy rates stood at 64 percent for urban hospitals and 47 percent for rural hospitals, a 17 percentage point difference. The occupancy rate in major teaching hospitals was 75 percent in 2004, the highest of all hospital groups.
- Since 1997, occupancy rates have gone up more for urban hospitals than rural hospitals, climbing 8 percentage points for urban hospitals and 4 percentage points for rural hospitals.
- Hospitals with lower occupancy rates (those in the bottom quartile) have lower Medicare and total (all payer) margins than hospitals in the top quartile of hospital occupancy rates. For example, in 2004, the aggregate overall Medicare margin for hospitals in the bottom quartile of occupancy was 7.0 percent lower than for hospitals in the top quartile.

Chart 7-7. Cumulative change in Medicare inpatient days per beneficiary and discharges per beneficiary, 1994–2003



Note: Cumulative change is the total percent increase from 1994 through the year indicated. Data are short-stay hospital Medicare patient days and discharges. Rate is per beneficiary enrolled in Part A. The statistics do not reflect managed care enrollment.

Source: MedPAC analysis of claims file and enrollment data from CMS.

- While discharges per beneficiary have increased, length of stay has fallen. Medicare hospital use rates increased from 1994 to 2003, with 8.4 percent more hospital discharges per enrollee at the end of the period. However, declining length of stay led to 15.5 percent fewer days of inpatient care for each enrollee in 2003 compared to 1994.

- There were 363 Medicare hospital discharges and 2,126 patient days per 1,000 beneficiaries enrolled in Part A in calendar year 2003.

Chart 7-8. Simulated Medicare inpatient payments, by component and hospital group, reflecting 2006 payment policy

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital*	
All hospitals	81.5%	4.9%	7.7%	4.0%	1.9%	$107,856
Urban	81.5	5.5	8.1	4.4	0.5	94,613
Rural	81.0	0.5	4.8	1.5	12.3	13,243
Large urban	79.9	6.7	8.7	4.7	0.1	53,955
Other urban	83.7	3.9	7.4	4.0	1.0	40,658
Rural referral	88.4	1.6	7.3	2.8	0.0	3,661
Sole community	70.3	0.2	2.0	0.7	26.9	6,005
Small rural Medicare-dependent	93.2	0.1	4.6	0.9	1.3	997
Other rural <50 beds	91.6	0.0	7.5	0.9	0.0	509
Other rural ≥50 beds	90.6	0.1	7.6	1.7	0.0	2,071
Voluntary	82.3	5.3	6.8	4.1	1.6	78,898
Proprietary	83.5	1.5	9.8	3.5	1.6	15,289
Government	74.2	6.3	10.9	4.5	4.1	13,642
Major teaching	67.3	16.2	10.5	5.9	0.1	23.818
Other teaching	83.9	3.6	7.6	3.9	1.0	38,278
Nonteaching	86.8	0.0	6.4	3.2	3.7	45,760

Note: IME (indirect medical education), DSH (disproportionate share). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Includes both operating and capital payments but excludes graduate medical education (GME) payments. Simulated payments reflect 2006 payments rules applied to actual number of cases in 2004. Actual payments in 2006 will likely be higher than shown due to growth in number of cases.

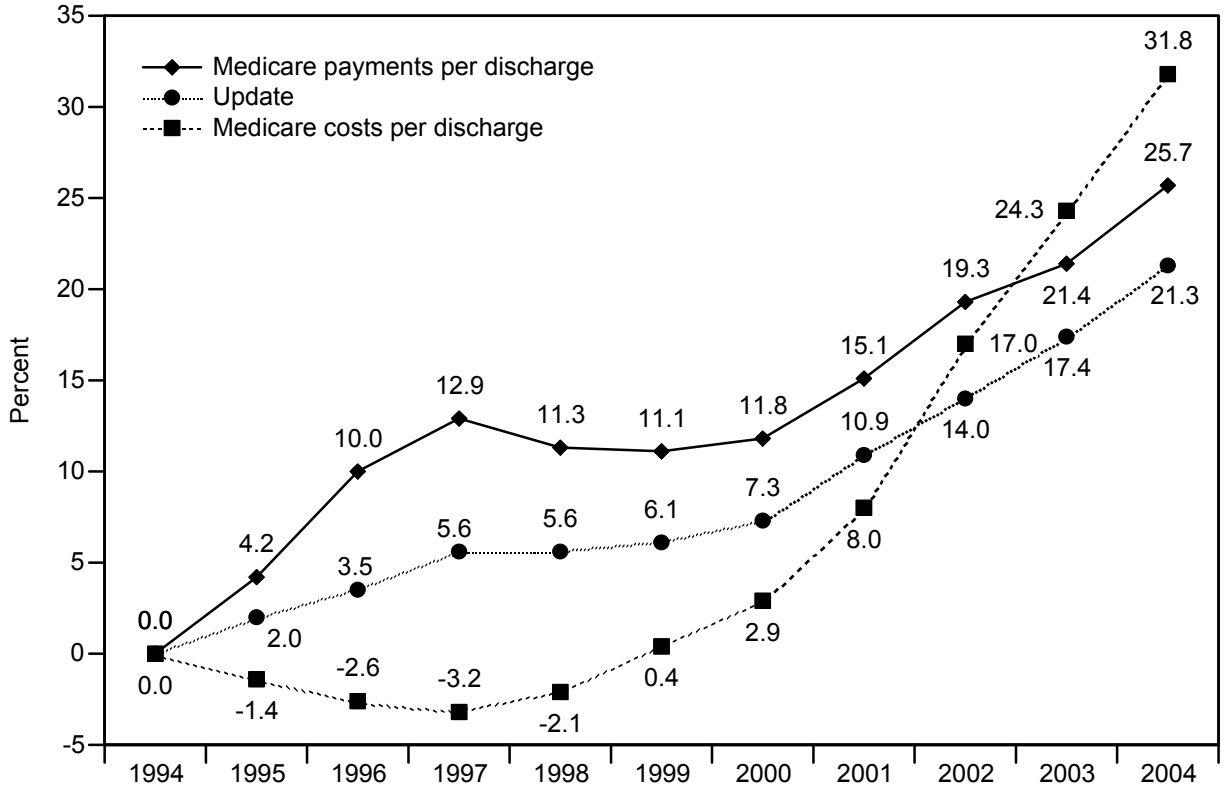
*Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- If the discharges that hospitals covered by the acute inpatient prospective payment system furnished in 2004 had been paid for under 2006 payment policies, then Medicare would have spent $108 billion. This figure is less than actual Medicare spending on hospital care in 2006 because it does not reflect increases in admissions from 2004 to 2006 and because it excludes payments made to critical access, rehabilitation, psychiatric, and long-term care hospitals as well as hospitals in Maryland and the U.S. territories.

- Special payments—which include disproportionate share (DSH), indirect medical education (IME) and outlier payments, as well as additional payments to rural hospitals through the sole community and Medicare-dependent programs—account for 19 percent of all inpatient payments. This proportion is slightly lower for urban than rural hospitals, although urban hospitals get most of their assistance from DSH, IME, and outlier payments while rural programs account for most of rural facilities' extra funds. Major teaching hospitals have the largest share of payments coming from special payments, about 33 percent.

Chart 7-9. Cumulative change in Medicare acute inpatient PPS payments and costs per case, and operating update, 1994–2004



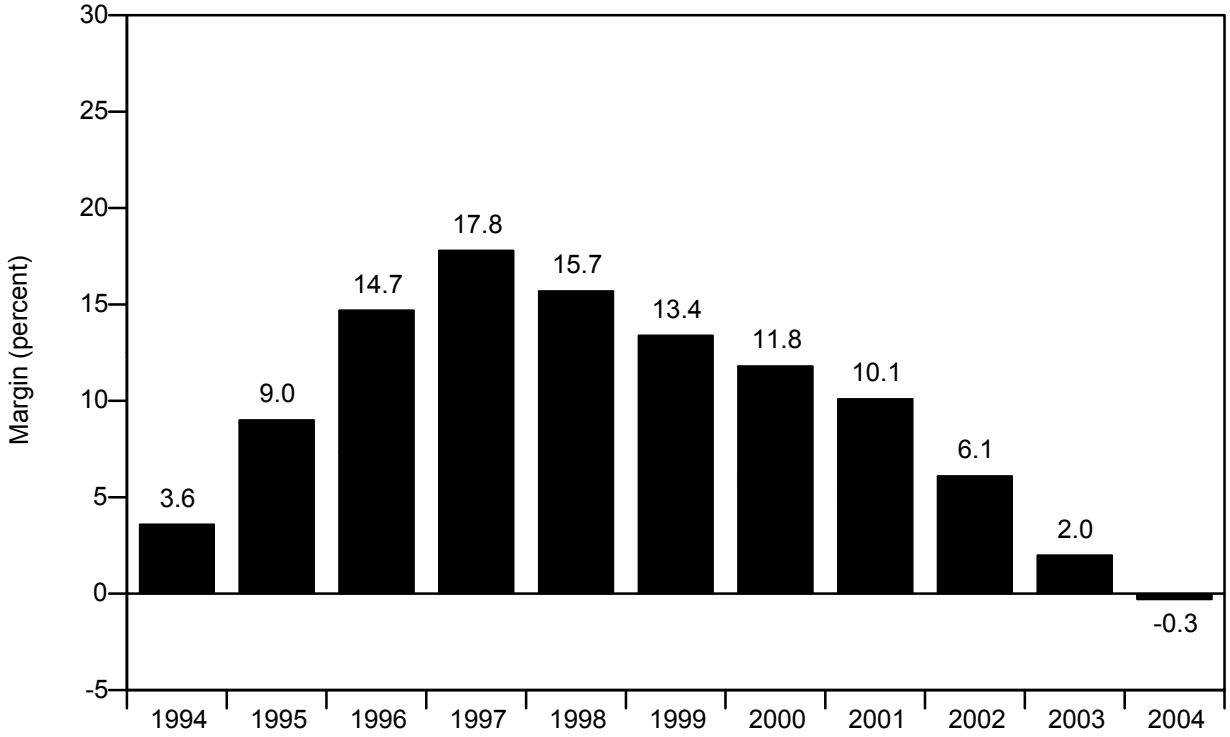
Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's acute inpatient PPS. Cumulative change is the total percent increase from 1994 to the year indicated.

Source: MedPAC analysis of Medicare cost report data and market basket data from CMS.

- From 1994 through 2002, cumulative growth in payments per case exceeded growth in costs per case. In recent years, however, hospitals' costs have increased much faster than the hospital market basket, due in part to the lack of financial pressure from private payers (see Chart 7-24).

- The cumulative update increased the inpatient operating payment rates 21.3 percent from 1994 to 2004, 10.5 percentage points less than the growth in hospitals' costs per discharge. However, hospitals' payment increases have exceeded the updates, due mostly to increases in case mix.

Chart 7-10. Medicare acute inpatient PPS margin, 1994–2004



Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

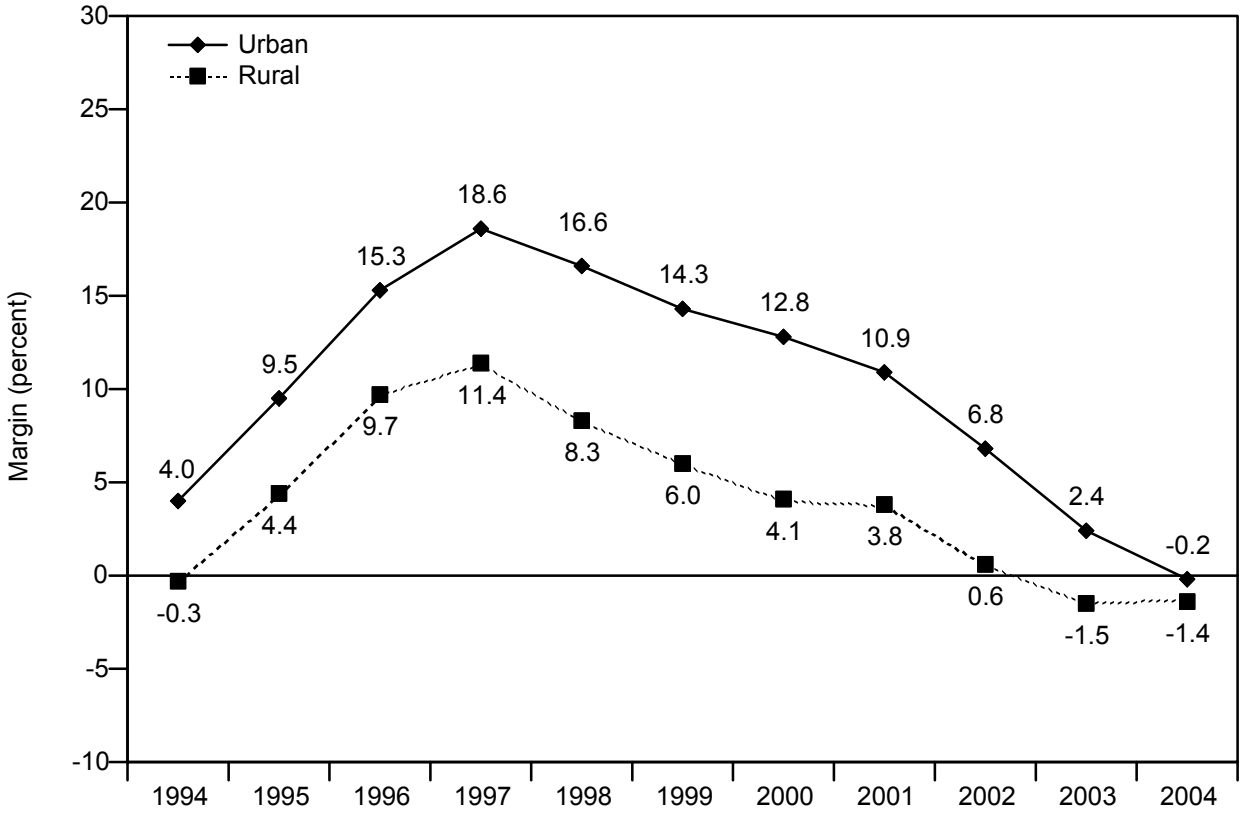
Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Medicare's acute inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs without the influence of how overhead costs are allocated.

- The Medicare inpatient margin increased steadily from 3.6 percent in 1994 to a record high of 17.8 percent in 1997. After implementation of the Balanced Budget Act of 1997, however, inpatient margins fell. In 2004, the margin was –0.3 percent, the lowest level since 1992.

- Medicare inpatient margins vary widely. In 2004, one quarter of hospitals had Medicare inpatient margins that were 10.0 percent or higher, and another quarter had margins that were –14.5 percent or lower. Between 1997 and 2003, this difference between the top and bottom quarter widened from 19 percent to 25 percent. About 47 percent of hospitals treating 41 percent of Medicare cases had positive inpatient Medicare margins in 2004.

Chart 7-11. Medicare acute inpatient PPS margins, by urban and rural location, 1994–2004



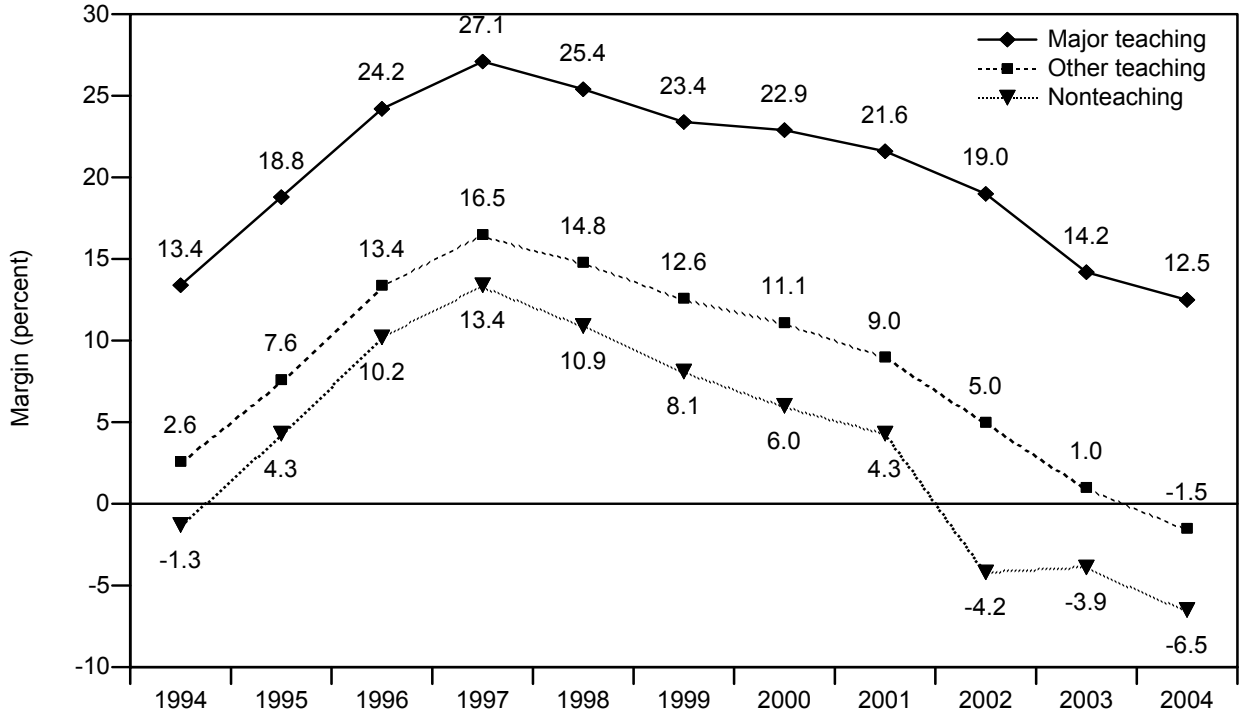
Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Medicare inpatient margins have consistently been higher for urban hospitals than for rural hospitals. A large part of this difference in financial performance can be explained by disproportionate share and indirect medical education adjustments that go primarily to urban hospitals.

- The gap between urban and rural hospitals' inpatient margins grew between 1994 and 2000. One factor in this divergence is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 through 2004, this difference narrowed substantially, as payment policies targeted at raising rural hospital payments were implemented.

Chart 7-12. Medicare acute inpatient PPS margins, by teaching status, 1994–2004



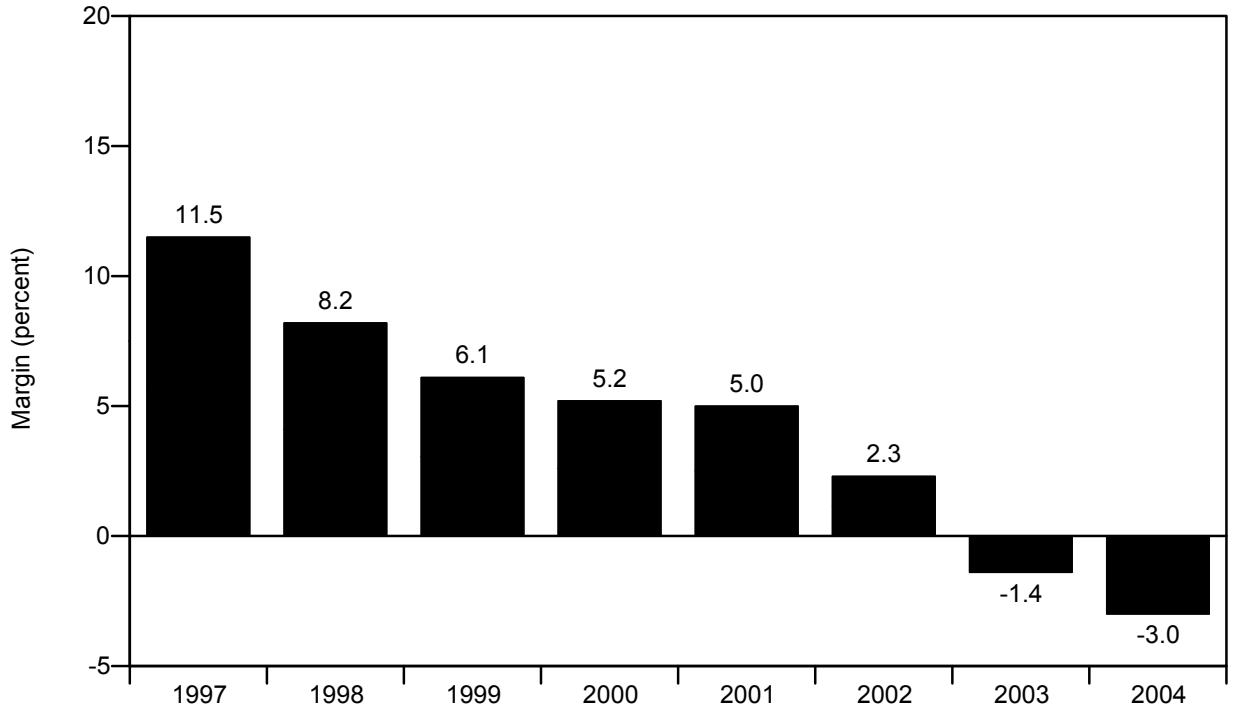
Note: PPS (prospective payment system). Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Major teaching hospitals have consistently had higher inpatient prospective payment system (PPS) margins than other teaching hospitals and nonteaching hospitals. Major and other teaching hospitals' better financial performance is due largely to the additional payments they receive from the indirect medical education and disproportionate share adjustments.

- Margins rose substantially for all groups through 1997, peaking at 27.1 percent for major teaching hospitals and 13.4 percent for nonteaching hospitals. Since then, inpatient margins have fallen less for major teaching hospitals than for nonteaching hospitals, dropping 14.6 and 19.9 percentage points, respectively, primarily reflecting lower growth in per case costs for major teaching hospitals.

Chart 7-13. Overall Medicare margin, 1997–2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

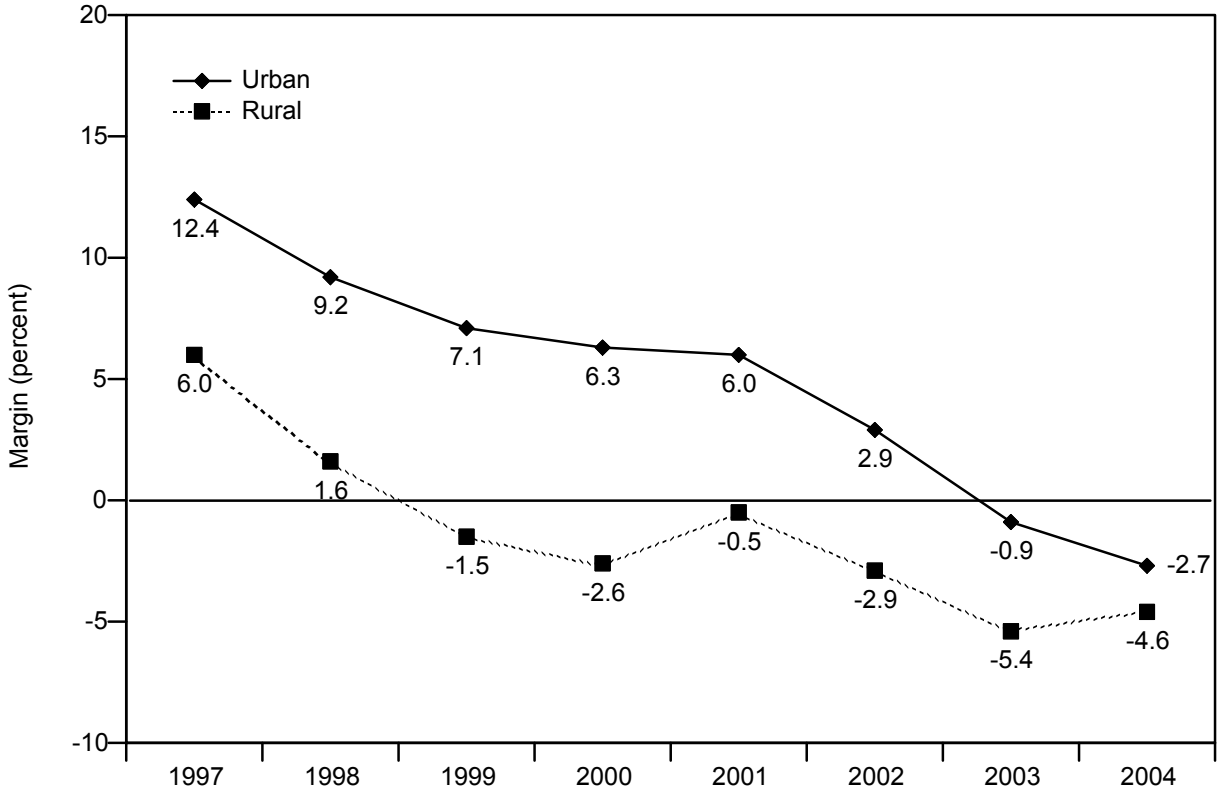
- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health, and inpatient psychiatric and rehabilitative services, as well as graduate medical education and bad debts. The overall margin is available only since 1997, but it follows a trend similar to that of the inpatient margin.

- The overall Medicare margin peaked in 1997 at 11.5 percent. In fiscal year 2004, it was –3.0 percent.

- In 2004, one quarter of hospitals had overall Medicare margins of 5.5 percent or higher, and another quarter had overall margins of –14.5 percent or lower. Between 1997 and 2004, the difference in performance between the top and bottom quartile widened from 14 percent to 20 percent. About 39 percent of hospitals had positive overall Medicare margins in 2004, accounting for 34 percent of Medicare inpatient discharges.

- We estimate that the overall Medicare margin in 2006—reflecting 2007 payment policies other than updates—will be –2.2 percent.

Chart 7-14. Overall Medicare margins, by urban and rural location, 1997–2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

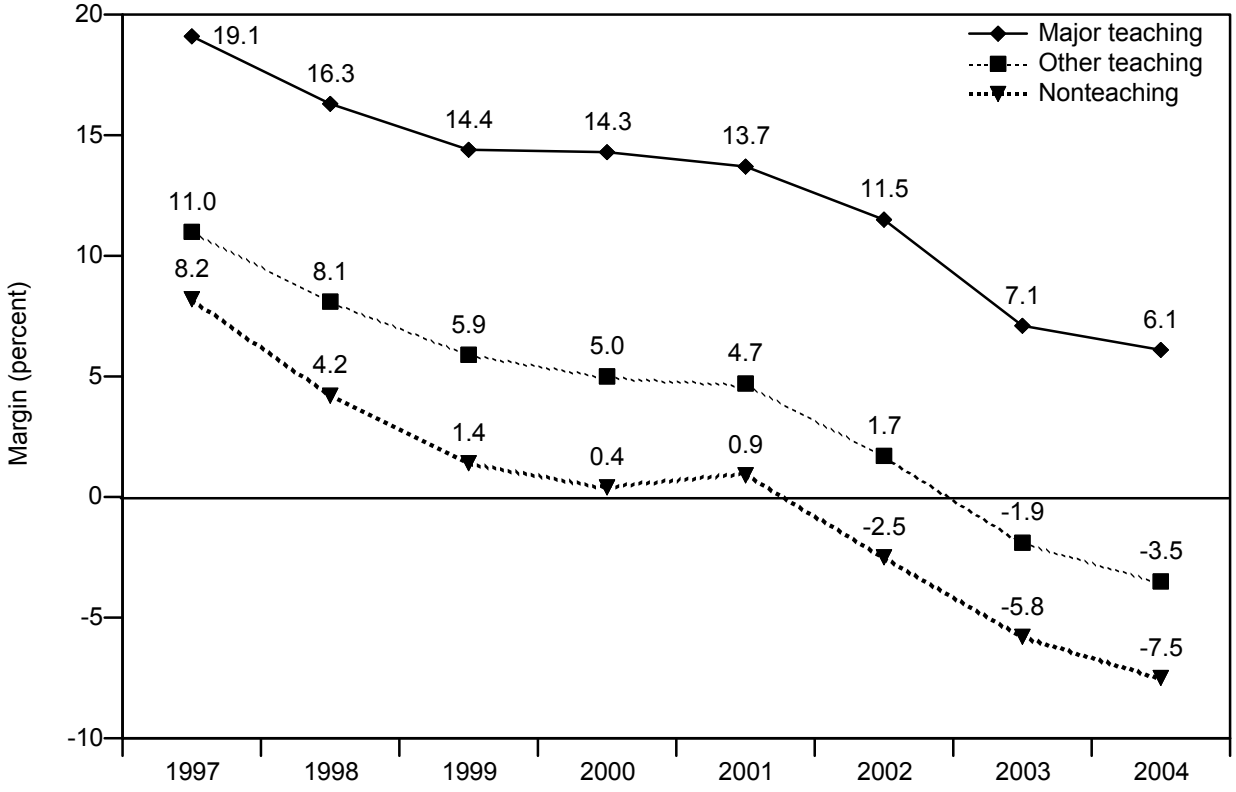
Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- As with inpatient margins, overall Medicare margins have been consistently higher for urban hospitals than for rural hospitals.

- The difference in margins between the two groups grew between 1997 and 2000 but has since narrowed. In 1997, the overall margin for urban hospitals was 12.4 percent, compared with 6.0 percent for rural hospitals. In 2004, the overall margin for urban hospitals was –2.7 percent, compared with –4.6 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals helped to narrow the difference in overall Medicare margins between urban and rural hospitals.

- A large part of the difference in financial performance between urban and rural hospitals is attributable to urban hospitals receiving more disproportionate share and indirect medical education payments.

Chart 7-15. Overall Medicare margins, by teaching status, 1997–2004



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payment of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

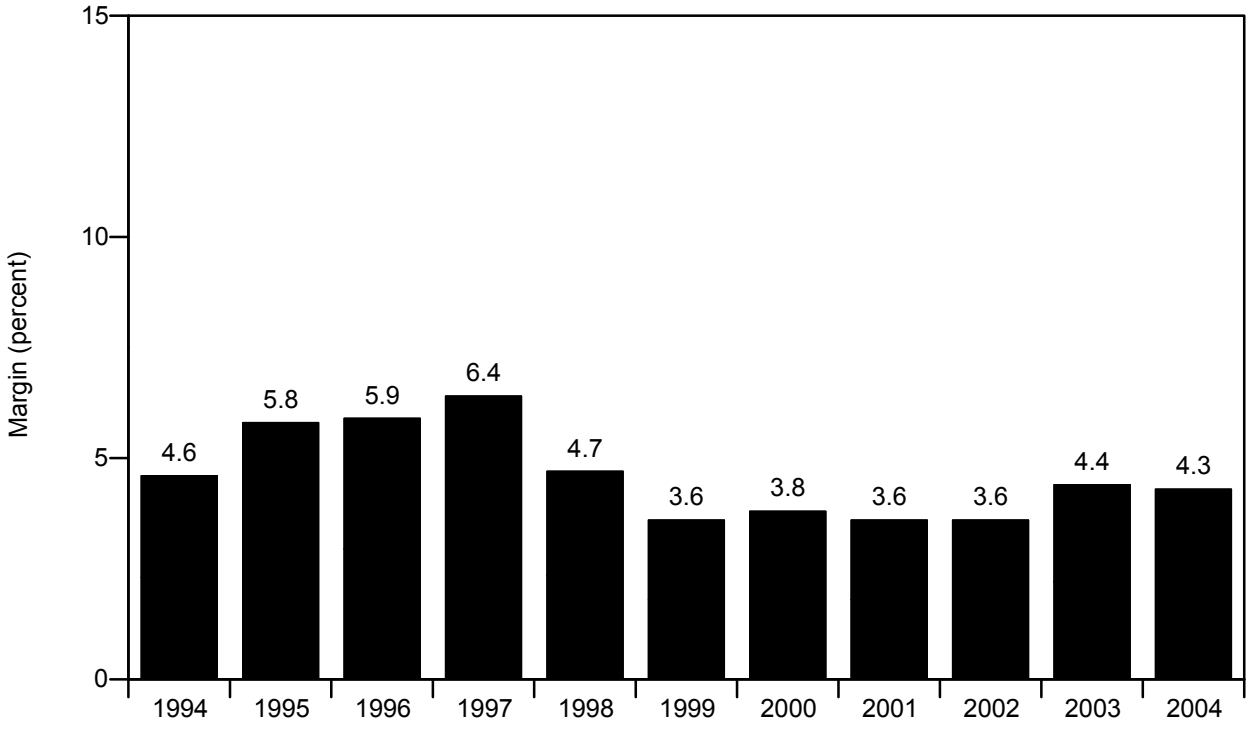
Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Major teaching hospitals consistently have had higher overall Medicare margins than other teaching hospitals and nonteaching hospitals primarily because of the additional payments they receive through the indirect medical education and disproportionate share adjustments under the acute inpatient payment system.

- In 2004, overall Medicare margins for major teaching hospitals were 6.1 percent, compared with –3.5 percent for other teaching and –7.5 percent for nonteaching hospitals.

- The difference in overall Medicare margins between major teaching hospitals and nonteaching hospitals grew from about 11 percentage points in 1997 to 14 percentage points in 2000, reflecting in part the lower cost growth of major teaching hospitals.

Chart 7-16. Hospital total margin, 1994–2004

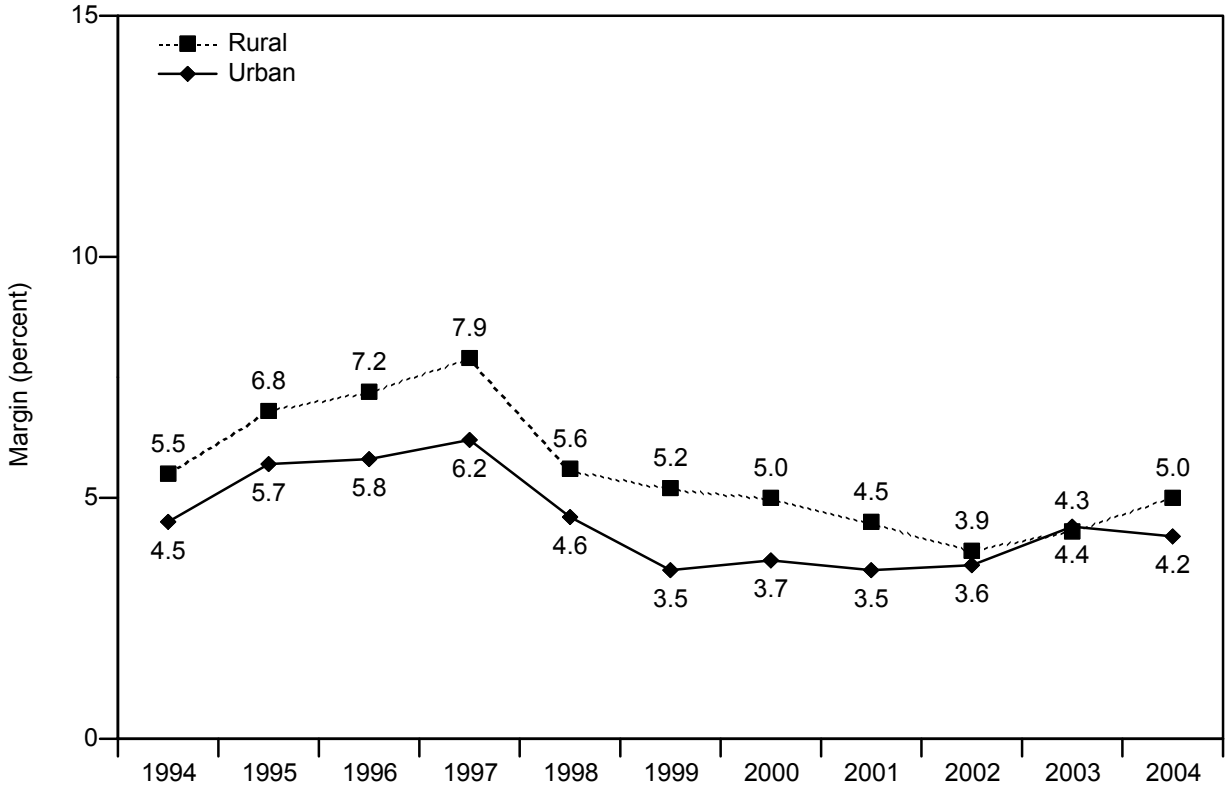


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, other government and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.
- The total hospital margin gradually climbed from 4.6 percent in 1994 to 6.4 percent in 1997, before declining to between 3.6 percent and 3.8 percent in the 1999 to 2002 period. In 2003, the total hospital margin climbed to 4.4 percent, its highest level in five years.
- The fall in total margins from 1997 to 1999 reflected a drop in both Medicare and private payer margins. Medicare overall margins from 1997 through 2001 were higher than the total margin.
- In 2004, 72 percent of hospitals had positive total margins. These hospitals accounted for 66 percent of all hospital discharges and 68 percent of Medicare discharges.
- The total margin varies much less than the Medicare inpatient or overall Medicare margin. In 2004, one quarter of PPS hospitals had total margins that were 7.3 percent or higher, while another quarter had margins that were –0.7 percent or lower, a spread of just 8 percentage points, compared to a 20 percentage point spread for overall Medicare margins and a 25 percentage point spread for Medicare inpatient margins.

Chart 7-17. Total hospital margin, by urban and rural location, 1994–2004

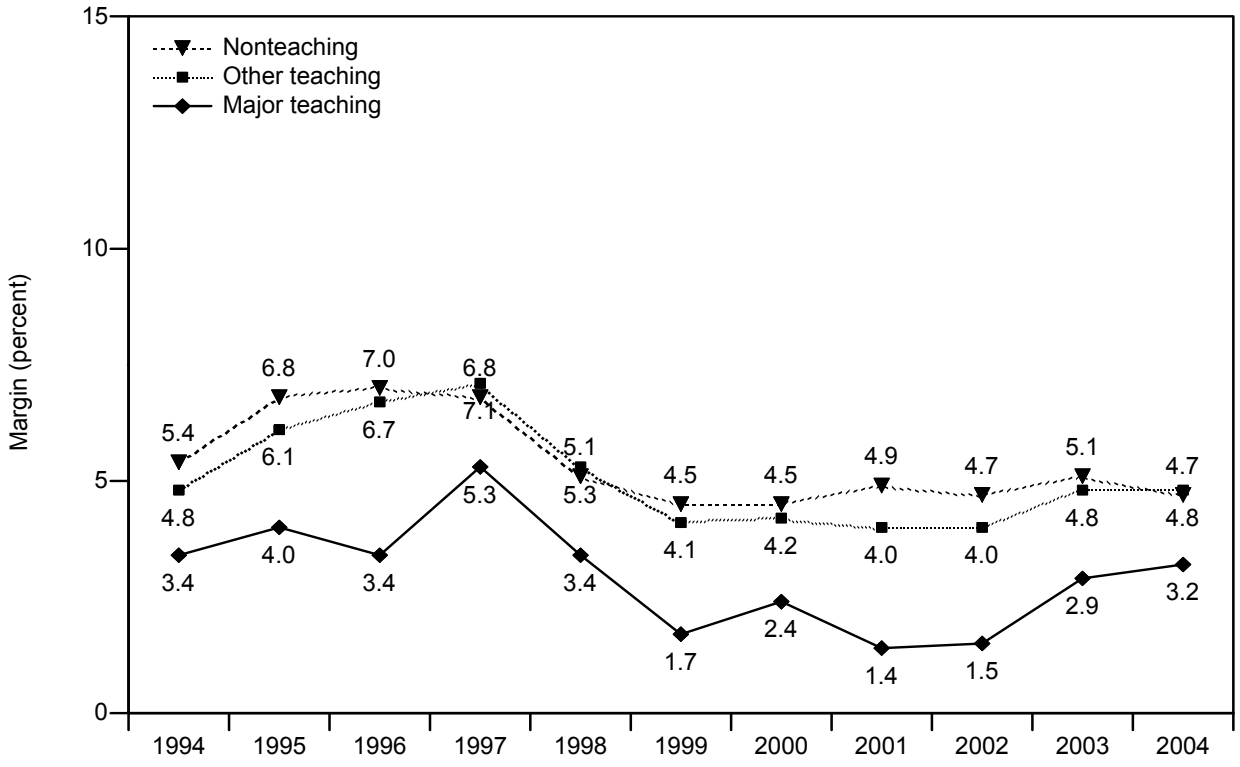


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Until 2002, total margins for rural hospitals were consistently about 1 percentage point higher than total margins for urban hospitals.
- In 2004, total margins for rural hospitals were 5.0 percent, and for urban hospitals they were 4.2 percent.

Chart 7-18. Total hospital margin, by teaching status, 1994–2004



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2004, the total margin for nonteaching hospitals stood at 4.7 percent compared with 3.2 percent for major teaching hospitals.

- The difference in margins between major teaching and nonteaching hospitals narrowed to only 1.5 percentage points in 2004, the smallest difference in over a decade.

Chart 7-19. Hospitals with consistently negative overall Medicare margins tend to have above-average costs

Hospital characteristic	Negative Medicare margin hospitals	Positive Medicare margin hospitals	All hospitals
Hospitals in group	986	828	2,923
(Share of total)	34%	28%	100%
Occupancy rate	52	58	55
Annual change in length of stay (1994–2004)			
Medicare	–2.4	–2.9	–2.6
All payers	–1.2	–1.5	–1.3
Standardized Medicare costs per discharge*	$5,428	$4,578	$5,053
Annual change in Medicare costs per discharge (2001–2004)*	6.6%	5.6%	6.4%

Note: Values shown are medians for all hospitals with positive or negative margins for four consecutive years, 2001–2004. Data are for 2004 unless otherwise noted.
*Standardized for differences in case mix and severity of illness (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare Cost Report files from CMS.

- Between 2001 and 2004, about 34 percent of hospitals had consistently negative overall Medicare margins while 28 percent had consistently positive overall Medicare margins.
- About 3 percent of hospitals had consistently negative Medicare and consistently negative total (all payer) margins.
- Hospitals with consistently negative margins tended to have lower occupancy rates (52 percent) and smaller declines in length of stay (–2.4 percent). The lower occupancy rates should translate into higher unit costs because fixed costs are spread over fewer units of output.
- Medicare standardized costs per discharge were substantially above average for the negative margin hospital group ($5,428) and substantially below average for the positive margin group ($4,578).
- Medicare costs per discharge increased more slowly in positive margin hospitals than in negative margin hospitals over the four years analyzed, contributing to a widening gap in performance.

Chart 7-20. Hospitals with consistently negative overall Medicare margins have a poor competitive position in their market areas

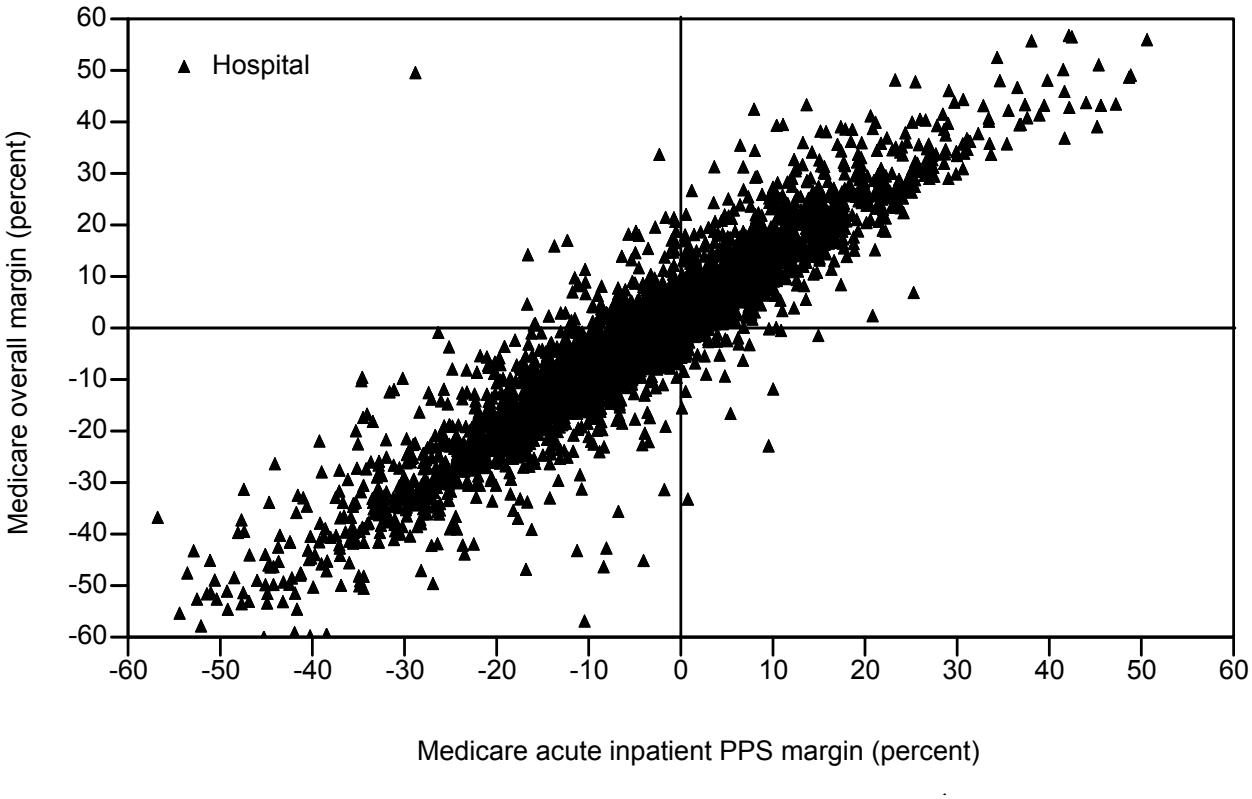
Variable	Occupancy rate 2004	Cost per discharge 2004*
Hospitals with consistently negative Medicare and total margins	44%	$5,276
Competitors within 15 miles	60	5,099
Hospitals with consistently negative Medicare margins only	52	5,428
Competitors within 15 miles	59	5,220
Hospitals with consistently positive Medicare margins	58	4,578
Competitors with 15 miles	60	4,908

Note: Hospitals with mixed performance are excluded from this table. Values shown are medians for all hospitals with consistently positive or negative margins for four consecutive years, 2001–2004.
*Costs per discharge are Medicare costs, standardized for differences in case mix and severity of illness (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare cost report data from CMS.

- Hospitals with consistently negative overall Medicare margins from 2001 through 2004 had poorer competitive positions in their market, with lower occupancy rates and higher costs per discharge than competitors within 15 miles.
- Hospitals with both negative overall Medicare margins and negative total margins had even lower occupancy rates (44 percent) than those with negative Medicare margins alone (52 percent). These hospitals only account for about 3 percent of providers.
- Hospitals with consistently positive margins had close to the same occupancy rate but lower costs than their neighboring facilities.

Chart 7-21. Relationship of acute inpatient PPS and overall Medicare margins, 2004

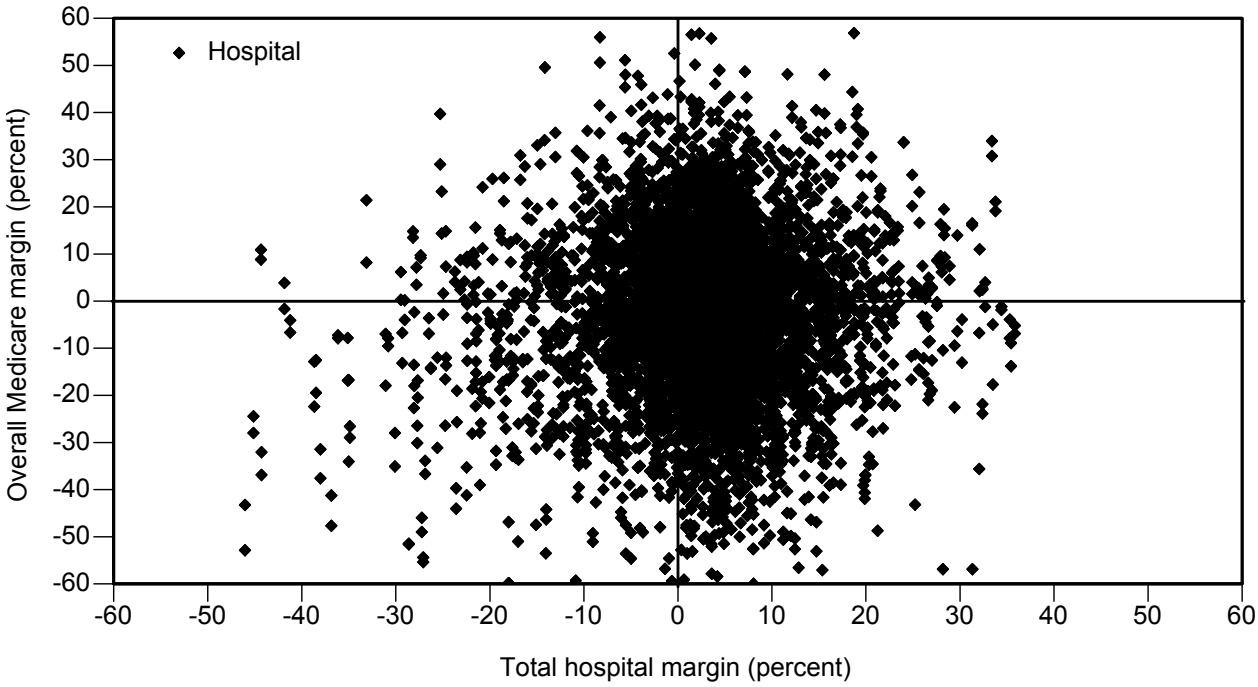


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. The Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The Medicare inpatient and overall margins are strongly correlated (R^2=0.776). The Medicare overall and inpatient PPS margins are closely related in part because inpatient payments make up about three-quarters of total Medicare payments.
- The Medicare overall margin tends to be lower than the inpatient margin, which may be overstated due to cost allocation bias.

Chart 7-22. Relationship of overall Medicare and total margins, 2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2000 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Total margin includes all patient care services funded by all payers, plus nonpatient revenues.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- There is little relationship between hospitals' overall Medicare margins and total (all payer) margins (R^2=0.006). That is, hospitals' performance in Medicare is not a good predictor of their performance across all payers and vice versa.

- Hospitals with negative Medicare margins and those with positive Medicare margins were almost equally likely to have positive total margins: 73 percent of hospitals with negative overall Medicare margins had positive total margins, while 71 percent of hospitals with positive Medicare margins had positive total margins.

- Hospitals in the upper right quadrant of the graph (28 percent) had positive overall Medicare margins and positive total margins in 2004, whereas hospitals in the lower left quadrant (17 percent) had negative overall Medicare margins and negative total margins.

Chart 7-23. Consistently high-cost hospitals have Medicare margins that are far below average

	Percent of hospitals	2002 to 2004 annual cost growth	2004 overall Medicare margin
Hospitals with consistently high costs	14%	6.6%	–16.6%
All hospitals	100	6.1	–3.0
Hospitals with consistently low costs	15	5.7	12.3

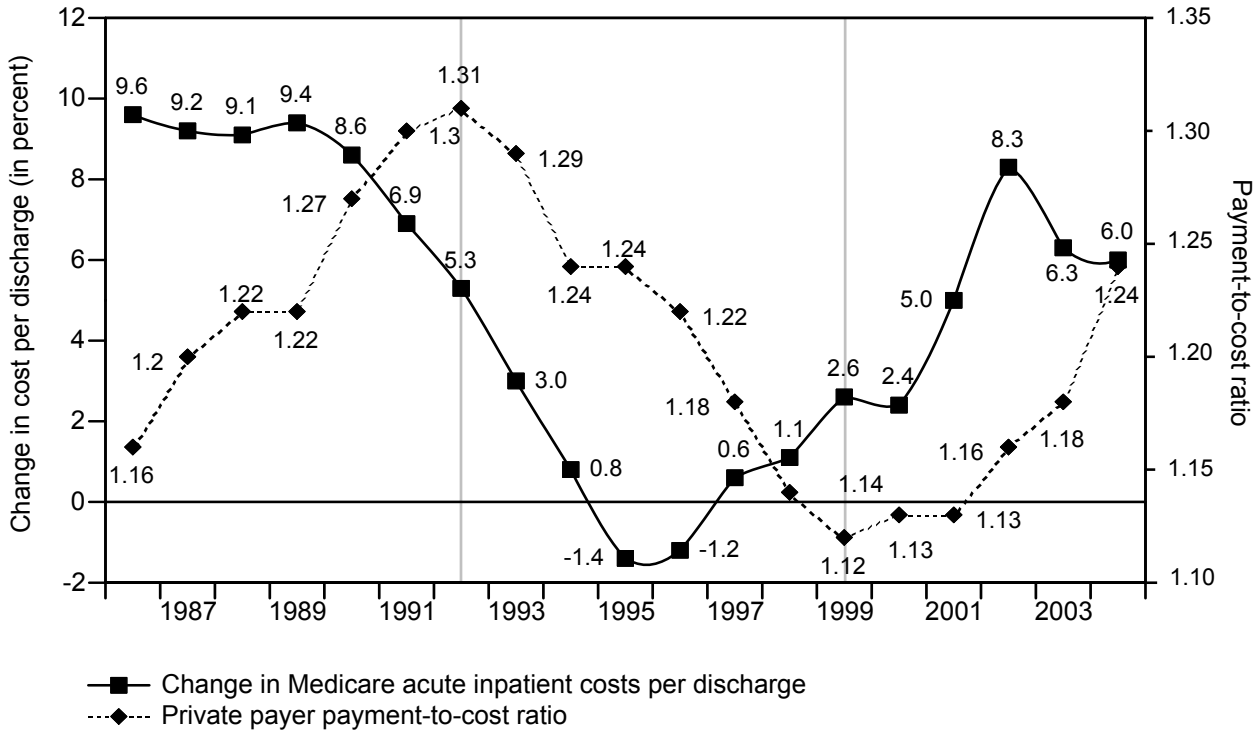
Note: Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Hospitals with consistently high or low costs are defined as in the highest or lowest quarter of all hospitals (ranked by standardized Medicare costs per discharge) in both 2002 and 2004. Costs were standardized for differences in case mix and patient severity (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare Cost Report data from CMS.

- About 14 percent of the hospitals covered by the acute inpatient prospective payment system (PPS) had consistently high costs, defined as being in the top quarter of all hospitals on a measure of standardized costs per case in both 2002 and 2004. About 15 percent of hospitals had consistently low costs, defined as being in the bottom quarter of all hospitals on the same measure in 2002 and 2004.

- Hospitals with consistently high costs have a substantial impact on the industry's financial performance under Medicare. These hospitals had an aggregate overall Medicare margin of –16.6 percent of 2004, substantially below the industry-wide figure of –3.0 percent. Consistently low-cost hospitals, in contrast, had a 12.3 percent margin.

Chart 7-24. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1986–2004



Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about one third of observations). Most Medicare and Medicaid managed care patients are included in this private insurer category.

Source: MedPAC analysis of Medicare Cost Report file from CMS and CMS's rules for the acute inpatient prospective payment system, and American Hospital Association Annual Survey of Hospitals.

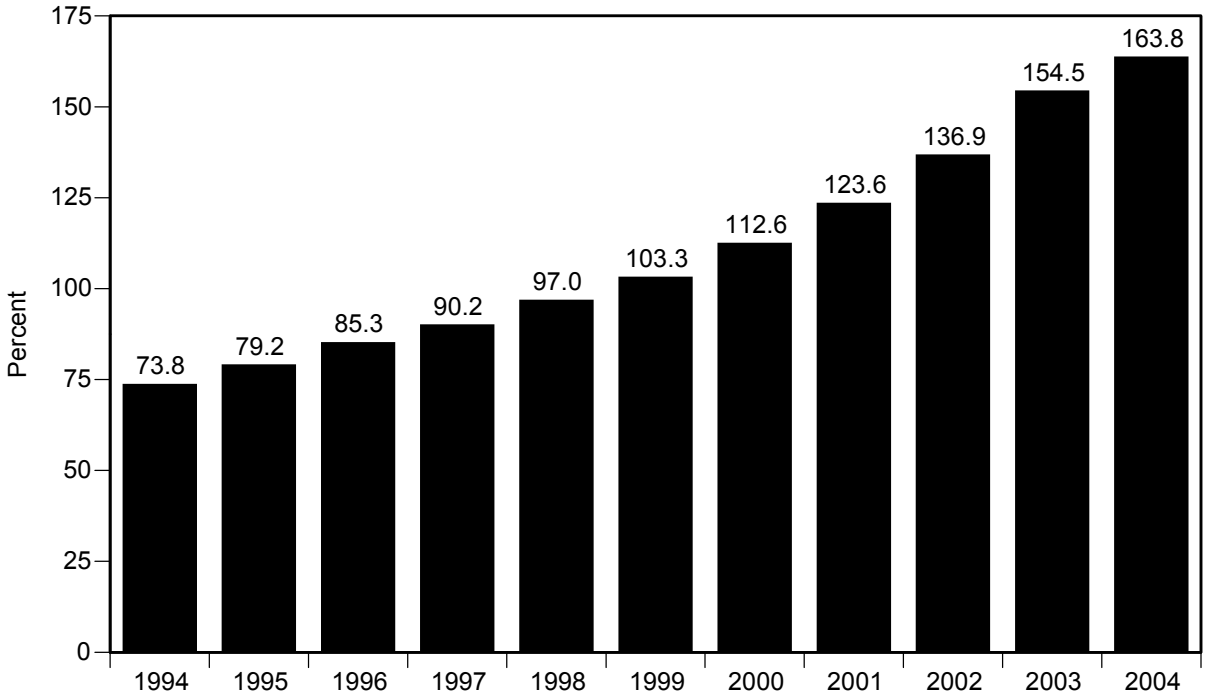
- The pattern of growth in Medicare costs per discharge makes it clear that hospitals have responded strongly to the incentives posed by the rise and fall of financial pressure from private payers over three periods.

- During the first period, 1986 through 1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year through these years, more than 3 percentage points a year above the increase in Medicare's market basket index.

- As HMOs and other private insurers exerted more pressure during the second period, 1993 through 1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to only 0.8 percent, which was more than 2 percentage points a year below the increase in the market basket.

- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio has again risen sharply, and hospital cost growth has once again exceeded growth in the market basket by 2 percentage points a year.

Chart 7-25. Markup of charges over costs for all patient care services, 1994–2004



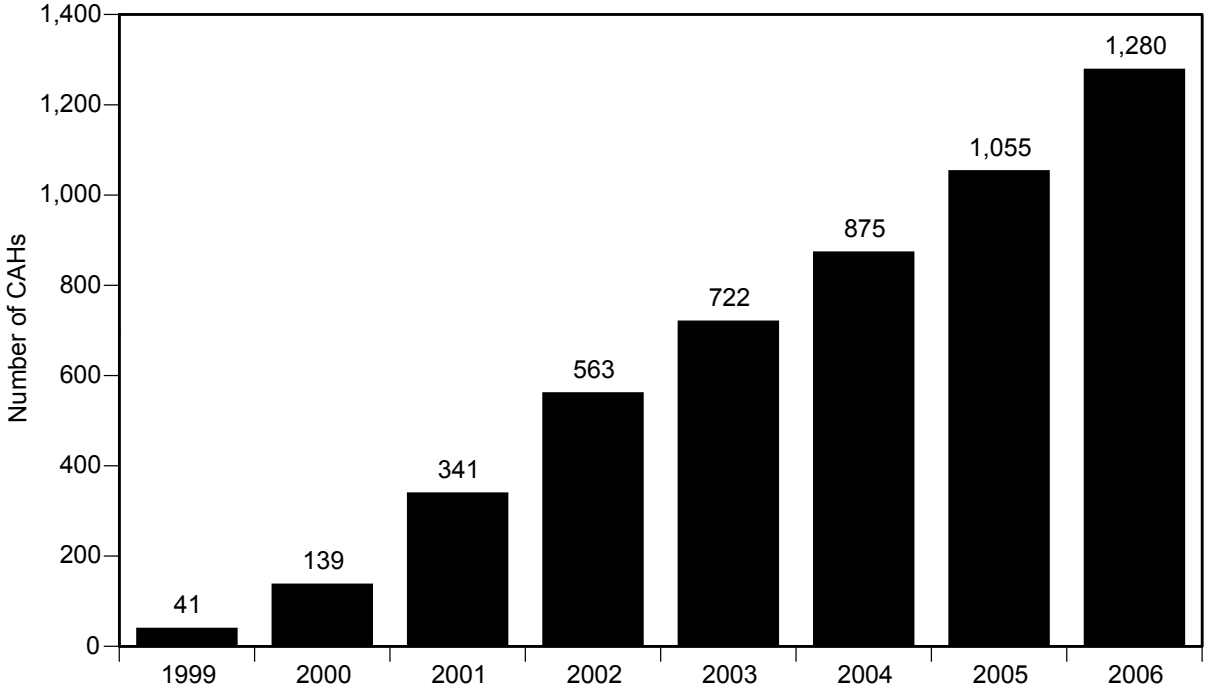
Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- From 1994 through 2004, hospitals' patient care costs (covering all services and all payers) increased 5.8 percent per year but their charges went up by 10.3 percent per year, nearly twice as much. Consequently, the markup of charges over costs rose from 74 percent in 1994 to 164 percent in 2004. Charges are now more than two and a half times costs. In 2002 and 2003, the growth in markup—about 15 percentage points per year—was the largest since Medicare's acute inpatient PPS was implemented. The markup grew by 9 percentage points in 2004.

- Since few patients pay full charges, hospitals' increasing their charges more than their costs may not have had much impact on their financial performance. Some are concerned, however, that uninsured individuals may be asked to pay full charges and may have collection proceedings applied against them. Faster growth rates for charges in recent years may have resulted from hospitals' attempting to maximize revenue from private payers (who often structure their payments as a discount off charges) or their revenue from Medicare outlier payments. In 2003, Medicare revised its outlier policy in an attempt to curb hospitals' opportunity to increase their outlier payments through excessive increases in their charges.

Chart 7-26. Number of critical access hospitals, 1999–2006



Note: Numbers of critical access hospitals are as of January 1 of each year.

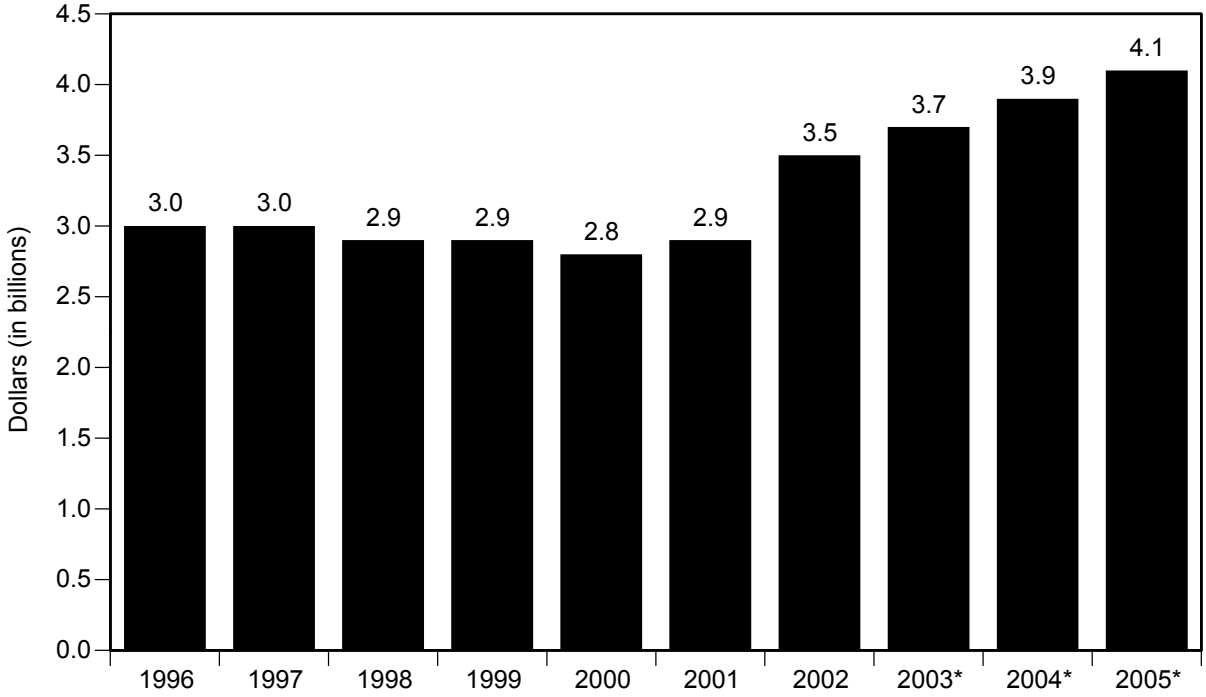
Source: *The Rural Hospital Flexibility Tracking Project.* Third-Year Findings, February 2003, and additional data from CMS.

- The increase in critical access hospitals (CAHs) is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs receive cost-based Medicare reimbursement for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.

- The number of CAHs has grown steadily over the last seven years, from 41 in 1999 to 1,280 at the beginning of 2006.

- Prior to 2006, hospitals could convert to CAH status if they were either (a) 35 miles by primary road from the nearest hospital or 15 miles by secondary road from the nearest hospital or (b) their state waived the distance requirement by declaring the hospital a "necessary provider." Starting in 2006, states can no longer waive the distance requirement. While most existing CAHs fail the distance test, they are grandfathered into the program. Among small rural PPS hospitals that have not converted, most would not meet the distance requirement. Therefore, we expect the number of CAHs to remain fairly constant at between 1,275 and 1,300 into 2007.

Chart 7-27. Medicare payments to inpatient psychiatric facilities, 1996–2005



Note: *Estimated spending.

Source: CMS, Office of the Actuary.

- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities was relatively stable from 1996 to 2001. Between 2002 and 2005, however, CMS estimates that program spending will increase 9 percent per year, rising to 4.1 billion dollars.
- Spending on inpatient psychiatric facilities makes up about 1 percent of Medicare's total spending.
- The inpatient psychiatric facility payment system started January 1, 2005.

Chart 7-28. Inpatient psychiatric facilities, 1996–2005

	1996	1998	2000	2002	2004	2005
Freestanding hospitals	642	627	582	503	478	470
Hospital-based units	1,445	1,489	1,487	1,437	1,389	1,328
Total	2,087	2,116	2,069	1,940	1,867	1,798

Source: Online Survey, Certification, and Reporting system from CMS.

- Inpatient psychiatric facilities—both freestanding and hospital-based facilities—provide acute hospital care to beneficiaries with mental illnesses or alcohol- and drug-related problems.
- From 1996 to 2005, the number of Medicare-certified freestanding inpatient psychiatric facilities decreased by 27 percent while the number of hospital-based units decreased by 8 percent, with a total loss of 14 percent of psychiatric facilities. In 2005, there are 1,798 inpatient psychiatric facilities—470 freestanding and 1,328 hospital-based units.

Web links. Acute inpatient services

Short-term hospitals

- Chapter 2A of the MedPAC March 2006 Report to the Congress provides additional detailed information on hospital margins.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 2A of the MedPAC March 2002 Report to the Congress provides information on the hospital market basket.

  http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2A.pdf

- MedPAC provides basic information about the acute inpatient prospective payment system.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_hospital.pdf

- Additional information on the outlier payment issue can be found in the Medicare 2002 Hospital Outlier Payment Policy.

  http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf

- CMS provides information on the hospital market basket.

  http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasket.asp

- CMS published the proposed acute inpatient PPS rule in the April 25, 2006 *Federal Register*.

  http://www.gpoaccess.gov/

Specialty psychiatric facilities

- CMS provides information on the inpatient psychiatric facility (IPF) prospective payment system.

  http://cms.hhs.gov/inpatientpsychfacilPPS/

- CMS also provides information on the final rule for these facilities rate year 2007 starting July 1, 2006.

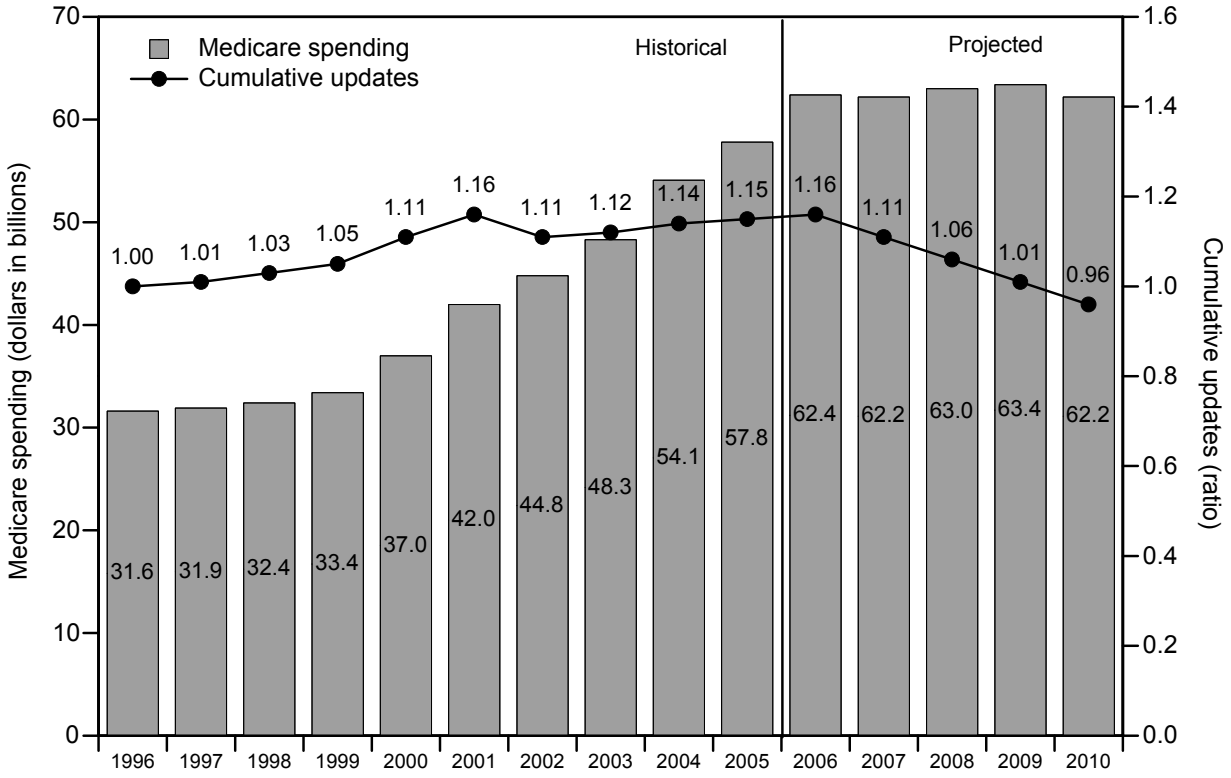
  www.cms.hhs.gov/inpatientpsychiatricfacilPPS/downloads/CMS-1306-F5-01-06.pdf

SECTION 8

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 8-1. FFS Medicare spending and payment updates for physician services, 1996–2010



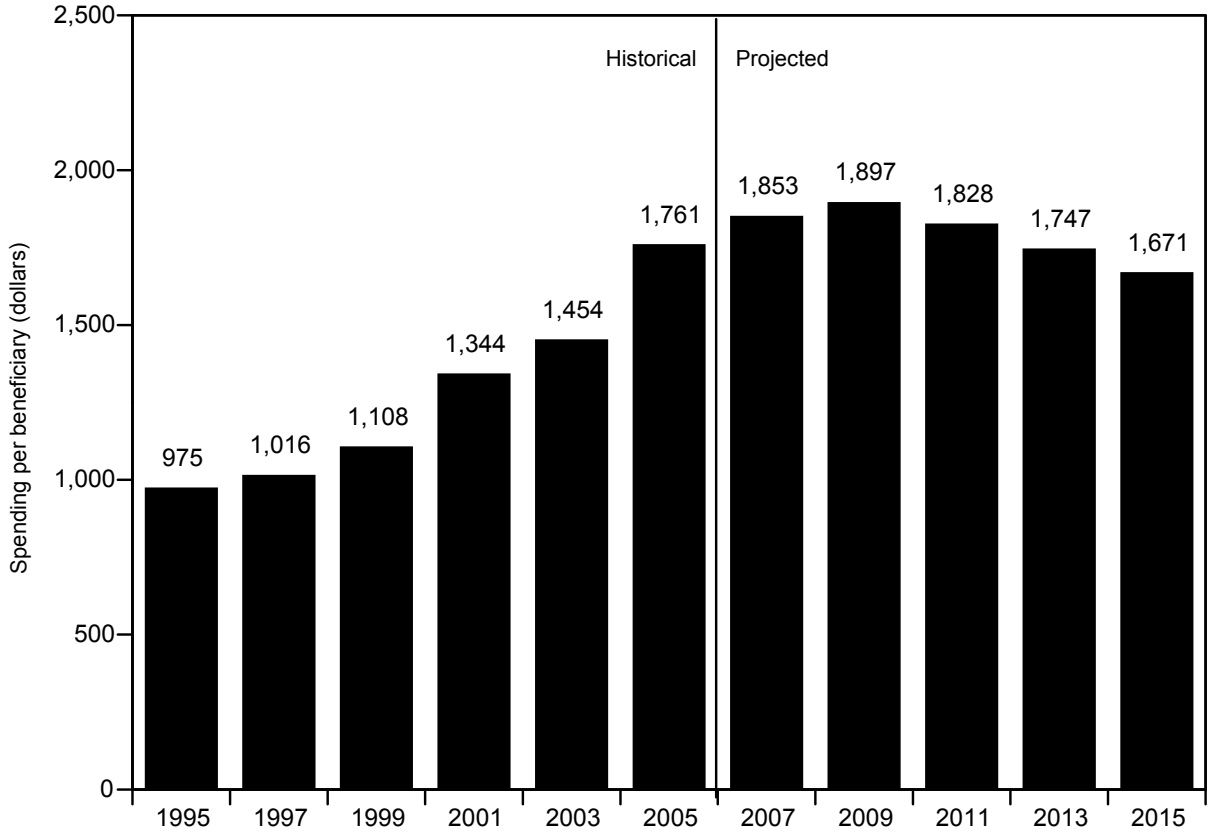
Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

- Between 1996 and 1999, Medicare spending on physician services was relatively flat. More rapid growth occurred between 1999 and 2005—averaging almost 10 percent annually.

- The sustainable growth rate system (SGR) requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in 2004 and 2005 physician fee schedule rates due to the SGR, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. For 2006, the Deficit Reduction Act froze the physician fee schedule conversion factor. This freeze, combined with refinements to the relative value units, results in an update of 0.2 percent for 2006. Under current law, payments for physician services are slated to decline about 5 percent for nine consecutive years, beginning in 2007.

Chart 8-2. Medicare spending per FFS beneficiary on physician services, 1995–2015



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

- Fee-for-service (FFS) physician spending per beneficiary has increased annually since 1995.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline beginning in 2007 because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.

Chart 8-3. Number of physicians billing Medicare is increasing steadily, 1999–2004

	Number of Medicare patients in caseload			
	≥15	≥50	≥100	≥200
Number of physicians				
1999	432,355	386,720	338,344	261,218
2000	444,187	398,905	351,012	274,059
2001	457,292	411,424	364,023	286,862
2002	466,299	419,269	370,144	291,593
2003	470,213	424,684	374,721	292,183
2004	483,945	440,462	393,730	315,398
Percent growth, 1999–2004	11.9%	13.9%	16.4%	20.7%
Physicians per 1,000 beneficiaries				
1999	11.7	10.4	9.1	7.1
2000	11.9	10.7	9.4	7.3
2001	12.1	10.9	9.7	7.6
2002	12.3	11.0	9.8	7.7
2003	12.3	11.1	9.8	7.6
2004	12.5	11.3	10.1	8.1

Note: Calculations include physicians (allopathic and osteopathic). Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. To calculate the ratios, Part B enrollment is used, which includes beneficiaries in fee-for-service Medicare and Medicare Advantage, on the assumption that physicians are providing services to both types of beneficiaries. To calculate physicians' Medicare caseload size, only fee-for-service beneficiaries are included.

Source: MedPAC analysis of Health Care Information System, 1999–2004, from CMS.

- The number of physicians providing services to beneficiaries has more than kept pace with growth in the beneficiary population. From 1999 to 2004, the number of physicians who billed Medicare grew faster than Medicare Part B enrollment. During this time Part B enrollment grew 4.8 percent, while the number of physicians with at least 15 Medicare patients grew by 11.9 percent. The number of physicians with 200 or more Medicare patients grew even faster at 20.7 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 11.7 to 12.5.

- The participation rate—that is, the percentage of physicians who can bill Medicare and who agree to accept assignment on all claims for payment during a year—has risen steadily over the past decade, reaching 92 percent in 2005.

- When physicians accept assignment, they accept Medicare's fee schedule amount as the service's full charge (of which 20 percent is beneficiary coinsurance). In 2004, 99 percent of allowed charges for physician services were assigned.

Chart 8-4. Spending growth varies by type of service, 2004−2005

Types of Services	Percent of spending	Spending change
Visits	37%	7%
Procedures	26	9
Imaging	14	16
Laboratory and other tests	12	11
Part B drugs	9	–3
Other	1	20
Total	100	8.5

Note: Other includes supplies and equipment furnished incident to physicians' services and medical nutritional therapy. In both columns of numbers, percentages may not necessarily add to the total, due to rounding. The total spending increase is a weighted average, so the spending increases by type of service do not sum to the total.

Source: Kuhn, H.B., CMS, Letter to MedPAC, April 7, 2006, and unpublished data from CMS.

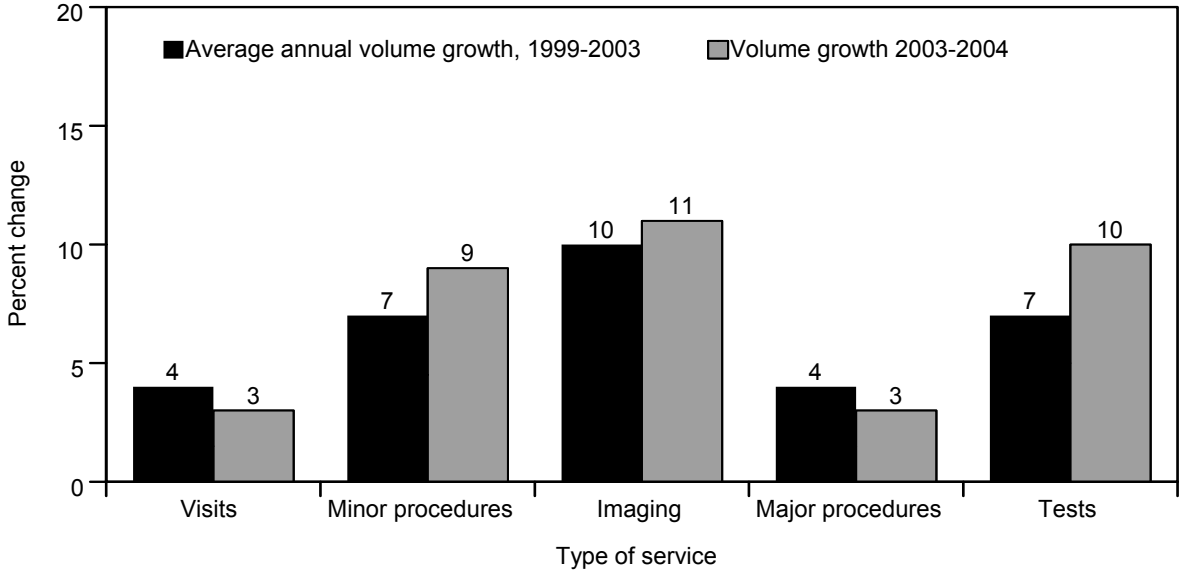
- Physician services can be classified by type of service. The visit category consists primarily of office visits but also includes consultations and visits to patients in facility settings. Procedures include major procedures such as open heart surgery, joint replacement, and back surgery and minor procedures such as colonoscopy, knee arthroscopy, and various eye procedures. Imaging includes x-rays of the chest, the musculoskeletal system, and other parts of the body as well as more advanced procedures, such as computed tomography and magnetic resonance imaging (MRI). Tests range from laboratory specimen analysis to electrocardiograms and cardiovascular stress tests. Part B drugs consist of covered drugs furnished in physician offices.

- Growth in spending for physician services varies by type of service. Between 2004 and 2005, growth was highest for imaging services and other services (e.g., supplies and equipment furnished incident to physicians' services and medical nutritional therapy).

- Spending on Part B drugs decreased between 2004 and 2005. CMS attributes much of the decrease to changes in Medicare's payment methodology.

- CMS attributes most of the overall rise in spending to growth in the volume and intensity of services.

Chart 8-5. Volume grew more rapidly in 2004 than in previous years



Note: Volume is measured as the units of service multiplied by each service's relative weight (relative value units) from the physician fee schedule. The measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 1999–2004.

- Across all services, volume grew 6.2 percent between 2003 and 2004. This growth is higher than the average annual volume growth of 5.4 percent seen between 1999 and 2003. Per capita volume for imaging grew the most. From 2003 to 2004, the imaging volume growth rate was 11.0 percent.

- These estimates include only services paid for under the physician fee schedule. The estimates would be higher if they included the volume of other services in CMS's broader definition of physician services, such as Medicare Part B drugs and laboratory services. The Commission had found, for example, that volume of chemotherapy drugs increased 12 percent from 2003 to 2004 and erythropoietin (for patients with end-stage renal disease) grew 36 percent.

- Volume growth for visits may be constrained by their greater dependence on actual physician time, compared with imaging and procedure-based services, which may rely more heavily on the aid of technology and nonphysician practitioners. Major surgical procedures are considerably less discretionary, and in some cases may be replaced by medical treatments or other procedures.

- It is not clear whether volume growth contributes to better health outcomes.

Chart 8-6. Medicare Economic Index input categories, weights, and projected price changes for 2007

Input component	Category weight	Price changes for 2007
Total	**100.0%**	**3.7%**
Physician work	**52.5**	**3.7%**
Wages and salaries	42.7	3.5
Fringe benefits (nonwage compensation)	9.7	4.5
Physician practice expense	**47.5**	**3.8**
Nonphysician employee compensation:	18.7	3.8
Wages and salaries	13.8	3.5
Fringe benefits (nonwage compensation)	4.8	4.6
Office expense	12.2	2.0
Professional liability insurance	3.9	8.6
Medical equipment	2.1	1.2
Drugs and supplies:	4.3	3.9
Pharmaceuticals	2.3	4.9
Medical materials and supplies	2.0	2.5
Other professional expense	6.4	2.4

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not sum to 100 percent due to rounding.

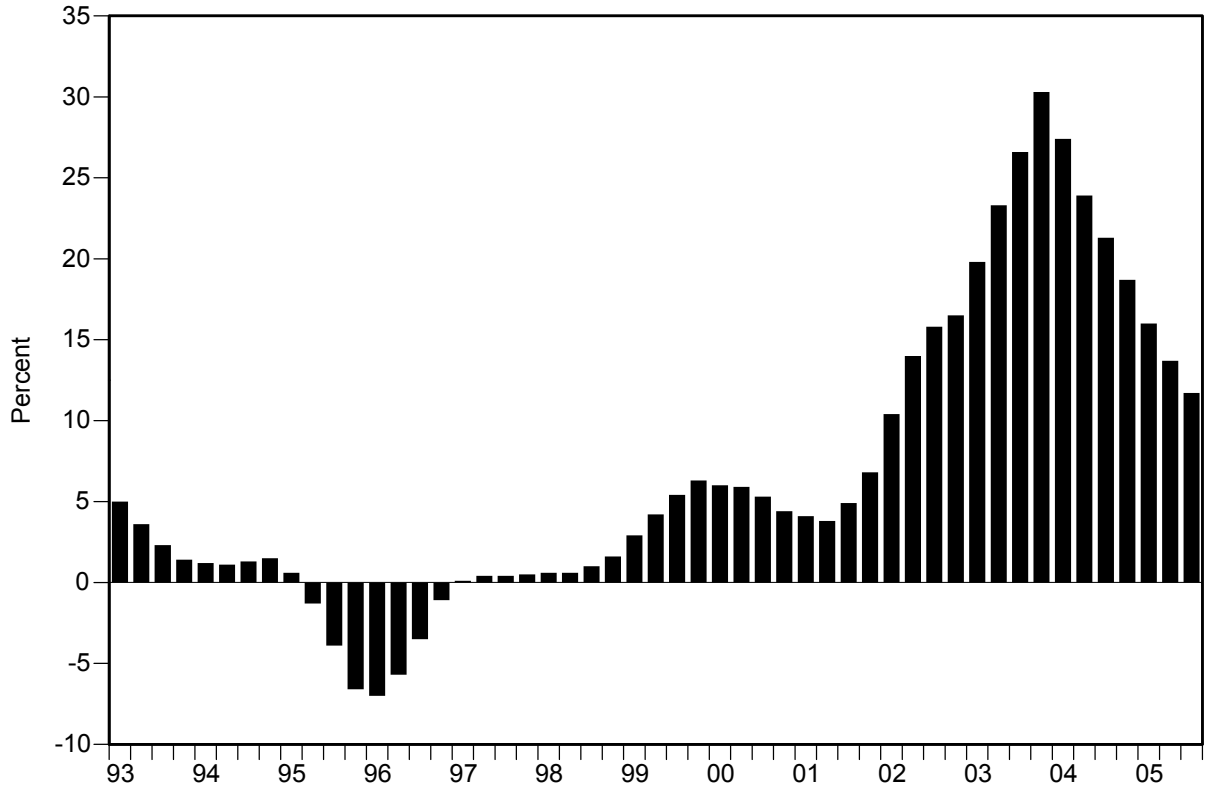
Source: Unpublished estimates from CMS, dated December 7, 2005.

- An important factor in determining the payment update for physician services is the projected change in input prices for physician services as measured by the Medicare Economic Index (MEI). The MEI is a weighted average of price changes for physician time and effort (i.e., work) and practice expense.

- CMS projects that input prices for physician work will increase 3.7 percent in 2007, based on increases of 3.5 percent in wages and salaries and 4.5 percent in nonwage compensation. Practice expenses are projected to increase 3.8 percent. This projection primarily reflects a 3.8 percent increase in nonphysician employee compensation and a 2.0 percent increase in office expenses.

- Professional liability insurance has the largest projected price change, 8.6 percent.

Chart 8-7. Quarterly changes in professional liability insurance premiums, 1993–2005

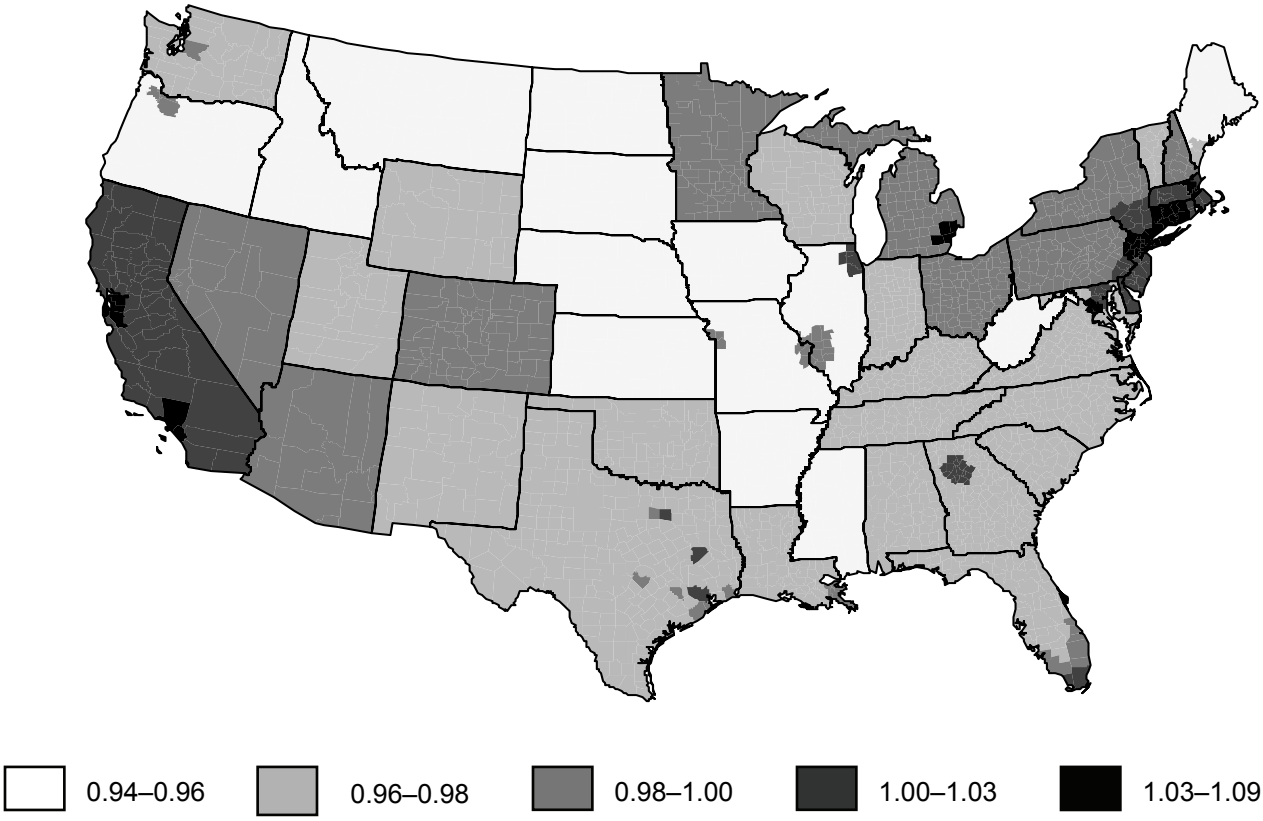


Source: MedPAC analysis of unpublished data from CMS.

- Historically, the professional liability insurance (PLI) component of the Medicare Economic Index followed a strong cyclical pattern, illustrated by the changes in PLI premiums from 1993 to 2001. The cycle was generally characterized by periods of low premiums, perhaps when insurers were building market share, and high premiums, perhaps when insurers were building reserves.

- Since 2001, changes in PLI premiums have departed from this cyclical pattern. The increase in the fourth quarter of 2003, estimated at 30.3 percent, was the highest in over a decade. Since then, change in PLI premiums has slowed, falling to 11.7 percent in the third quarter of 2005, but still remains greater than in the pre-2001 period.

Chart 8-8. Work GPCI before the MMA established a floor of 1.00



Note: GPCI (geographic practice cost index), MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

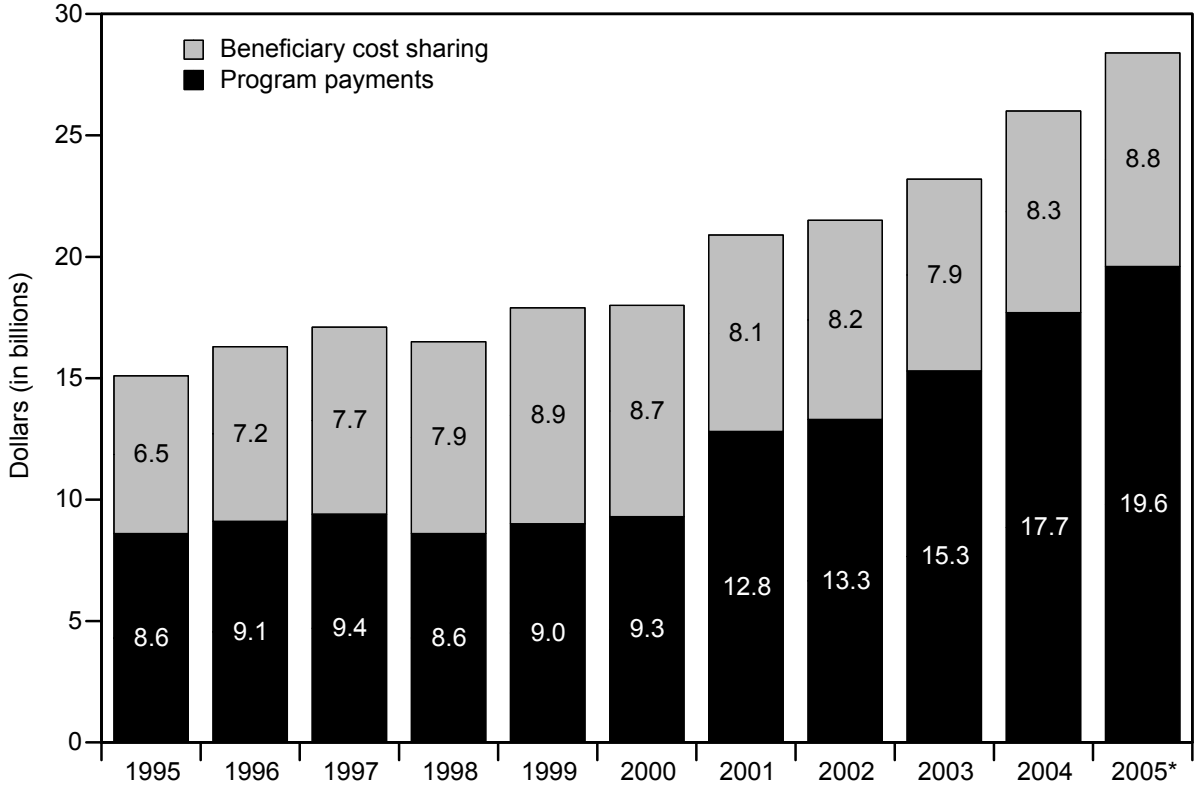
Source: Geographic practice cost index from CMS.

- Under Medicare's physician fee schedule, geographic practice cost indexes (GPCIs) adjust payment rates to account for differences in the price of inputs used in furnishing physician services. There are three GPCIs, one corresponding to each component of the relative value scale: physician work, practice expense, and professional liability insurance (PLI). The three GPCIs are applied to determine rates for each of 89 payment areas. Of the 89 areas, 34 are statewide.

- Prior to the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the work GPCI ranged from 0.94 to 1.09. The MMA temporarily reduced this variation by establishing a three-year floor for the work GPCI of 1.00.

- The work GPCI floor will expire on December 31, 2006, at which point it is expected that work GPCIs will again vary widely across the 89 payment areas nationwide.

Chart 8-9. Spending on all hospital outpatient services, 1995–2005



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services or durable medical equipment) or those paid on a cost basis (e.g., organ acquisition or flu vaccines). They do not include payments for clinical laboratory services.
* Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) almost doubled from calendar year 1995 to 2005, reaching $28.4 billion. The Office of the Actuary projects continued growth in total spending, averaging 7.5 percent per year from 2002 to 2007.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 90 percent of spending on all hospital outpatient services.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $19.2 billion, including $11.4 billion by the program and $7.7 billion in beneficiary cost sharing. By 2005, spending under the outpatient PPS is expected to rise to $25.9 billion ($17.6 billion program spending; $8.3 billion beneficiary copayments). The outpatient PPS accounted for about 5 percent of total Medicare spending by the program in 2005.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 32 percent in 2005. Chart 8-13 provides more detail on coinsurance.

Chart 8-10. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2002	4,210	94	84	93
2003	4,079	94	86	93
2004	3,882	94	86	92

Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

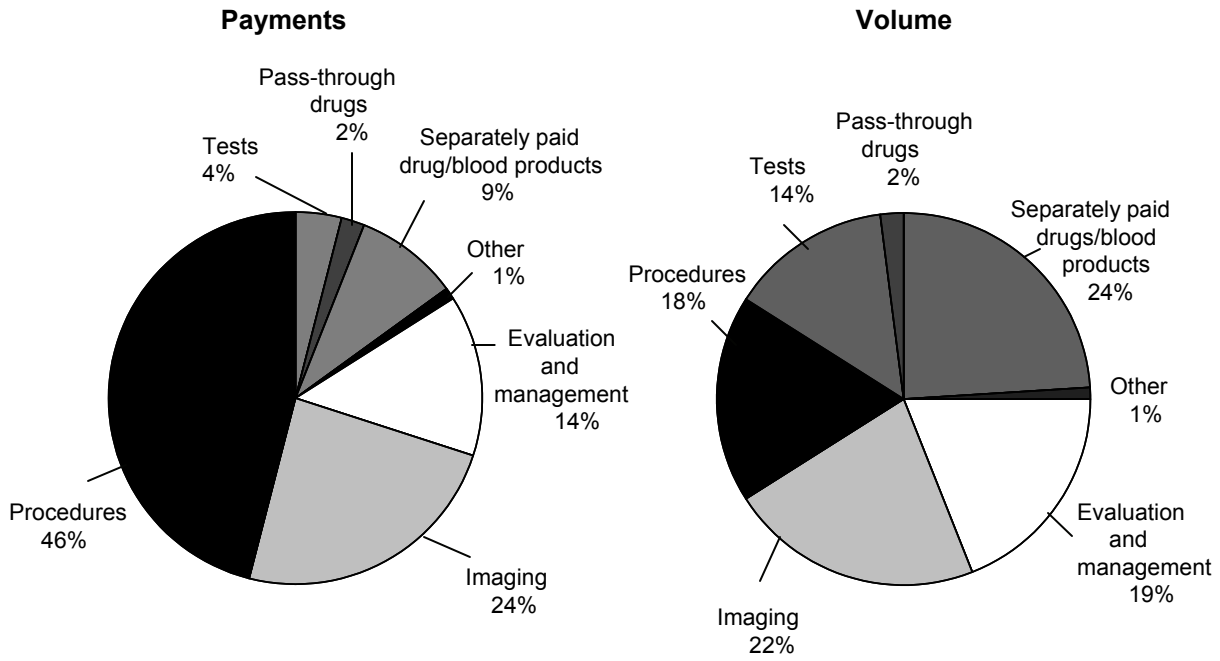
Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system has declined, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. However, the percent of hospitals providing outpatient services and emergency services has remained stable, and the percent providing outpatient surgery has increased.

- Almost all hospitals provide outpatient (94 percent) and emergency (92 percent) services. The vast majority (86 percent) provide outpatient surgery.

- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system.

Chart 8-11. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2004



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing but do not include transitional corridor payments (see Chart 8-14 for further information regarding transitional corridor payments). Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for 2004 from CMS.

- The volume of services is distributed differently than payments. For example, procedures account for 18 percent of the volume, but 46 percent of the payments.
- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- Over 40 percent of the services provided in hospital outpatient departments are evaluation and management or imaging services.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of spending on services (46 percent), followed by imaging services (24 percent), and evaluation and management (14 percent).
- In 2004, separately paid drugs and blood products accounted for 9 percent of spending.

Chart 8-12. Hospital outpatient services with the highest Medicare expenditures, 2004

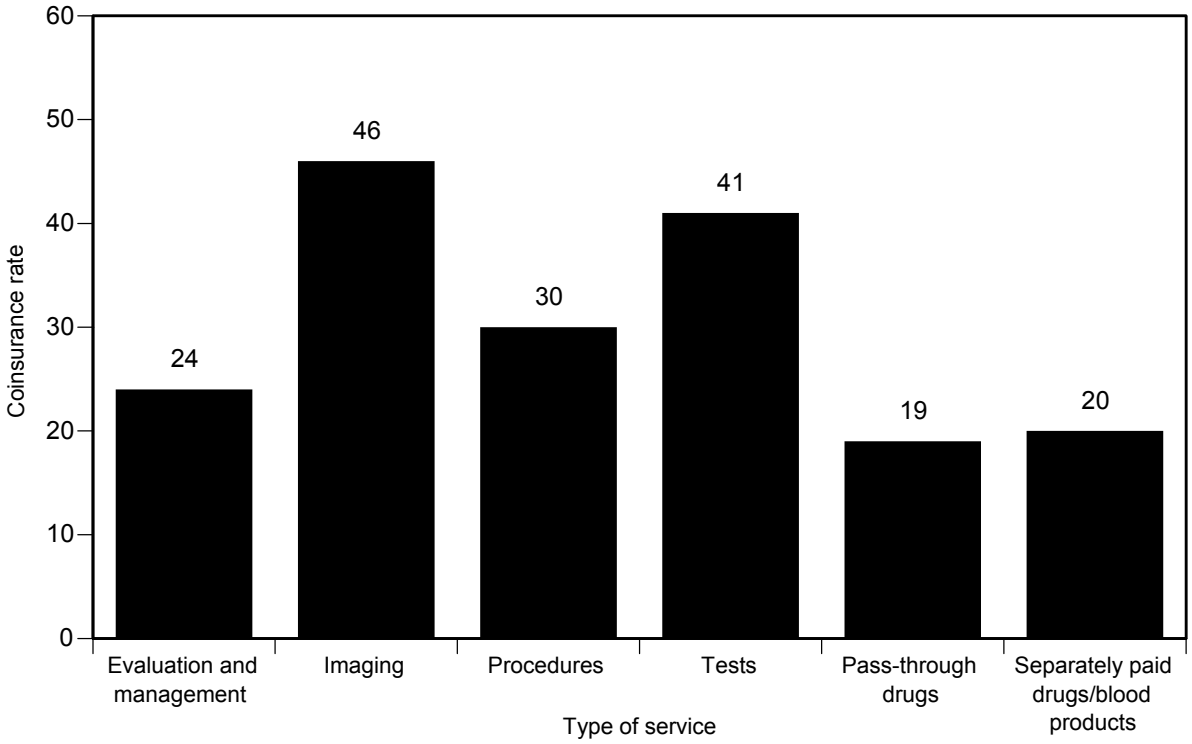
APC	Title	Share of payments
Total		48
0610, 0611, 0612	All emergency visits	7%
0600, 0601, 0602	All clinic visits	4
0246	Cataract procedures with IOL insert	4
0283	CT with contrast material	4
0080	Diagnostic cardiac catheterization	3
0260	Level I plain film except teeth	3
0143	Lower gastrointestinal endoscopy	3
0332	CT and computerized angiography without contrast material	3
0301	Level II radiation therapy	3
0336	MRI and magnetic resonance angiography without contrast	2
0337	MRI and magnetic resonance angiography without contrast material followed by contrast material	2
0280	Level III angiography and venography except extremity	2
0141	Upper gastrointestinal procedures	2
0120	Infusion therapy except chemotherapy	1
0325	Group psychotherapy	1
0333	Computerized axial tomography and computerized angio w/o contrast material followed by contrast	1
0377	Level III cardiac imaging	1
0733	Non-ESRD epoetin alpha injection, 1,000 units	1
0131	Level II laparoscopy	1
0267	Level III diagnostic ultrasound except vascular	1
0154	Hernia/hydrocele procedures	1

Note: APC (ambulatory payment classification), IOL (intraocular lens), CT (computed tomography), MRI (magnetic resonance imaging), ESRD (end-stage renal disease). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of the 100 percent analytic file of outpatient prospective payment system claims for calendar year 2004.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 8-13. Medicare coinsurance rates, by type of hospital outpatient service, 2004



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicators. There is no beneficiary copayment for pass-through devices.

Source: MedPAC analysis of 100 percent special analytic file of 2004 outpatient prospective payment system claims and payment rates.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.
- In adopting the outpatient prospective payment system, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging, have very high rates of coinsurance—46 percent. Other services, such as clinic visits, have coinsurance rates of 20 percent.
- In 2004, the overall coinsurance rate was about 33 percent.

Chart 8-14. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2002–2004

	2002		2003		2004	
Hospital group	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors
All hospitals	3,636	2.5%	3,621	2.4%	3,368	0.9%
Urban	2,425	2.3	2,421	1.9	2,344	0.5
Rural ≤ 100 beds	933	5.8	929	7.7	768	5.4
Rural >100 beds	278	1.1	271	1.6	256	0.6
Major teaching	289	5.0	284	3.6	279	0.9
Other teaching	770	1.5	760	1.5	739	0.3
Nonteaching	2,577	2.1	2,577	2.5	2,350	1.2

Note: A small number of hospitals could not be classified due to missing data.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

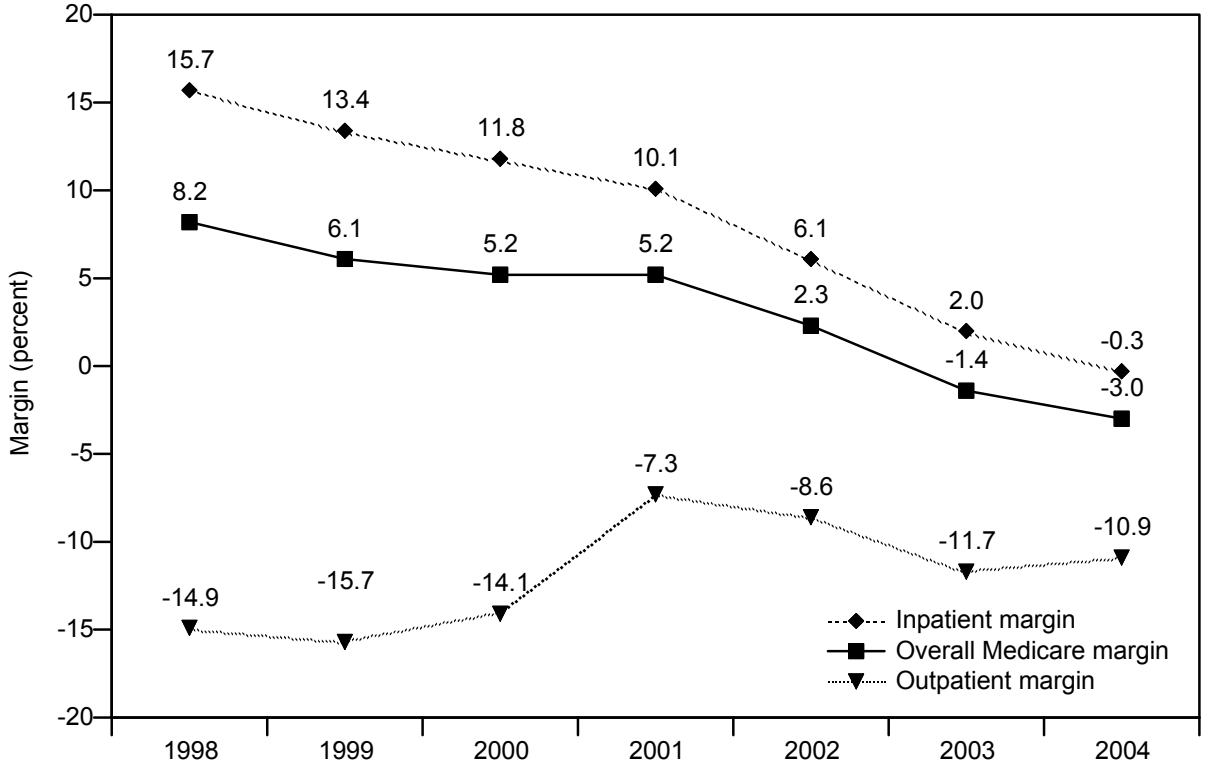
- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a payment schedule based on average (median) costs for all hospitals.

- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.

- Transitional corridor payments represented 2.5 percent of total outpatient PPS payments in 2002, declining to 2.4 percent in 2003, then to 0.9 percent in 2004. The decline from 2003 to 2004 is due to the expiration of transitional corridor payments for most hospitals on December 31, 2003. However, the payments continued for two more years—through December 31, 2005—for rural sole community hospitals and other rural hospitals with 100 or fewer beds. The Deficit Reduction Act of 2005 extended most of the transitional corridor payments for rural hospitals with 100 or fewer beds through December 31, 2008.

- In 2004, rural hospitals with 100 or fewer beds received 5.4 percent of their payments from transitional corridor payments.

Chart 8-15. Medicare hospital outpatient, inpatient, and overall Medicare margins, 1998–2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2004, while the aggregate margin was –10.9 percent, 25 percent of hospitals had margins of –21.2 percent or lower, and 25 percent had margins of –1.8 percent or higher.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.

- The improvement in outpatient margins from 1999 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined somewhat from 2001 to 2003. This may reflect the decline in the number of drugs and devices eligible for pass-through payments. The margin improved in 2004, perhaps due to many drugs becoming specified covered outpatient drugs (SCODS). In 2004 and 2005, these drugs were paid on the basis of average wholesale price, which increased their payment rates. These additional payments were not budget neutral, so aggregate outpatient payments increased.

Chart 8-16. Number of Medicare-certified ASCs increased over 60 percent, 1999–2005

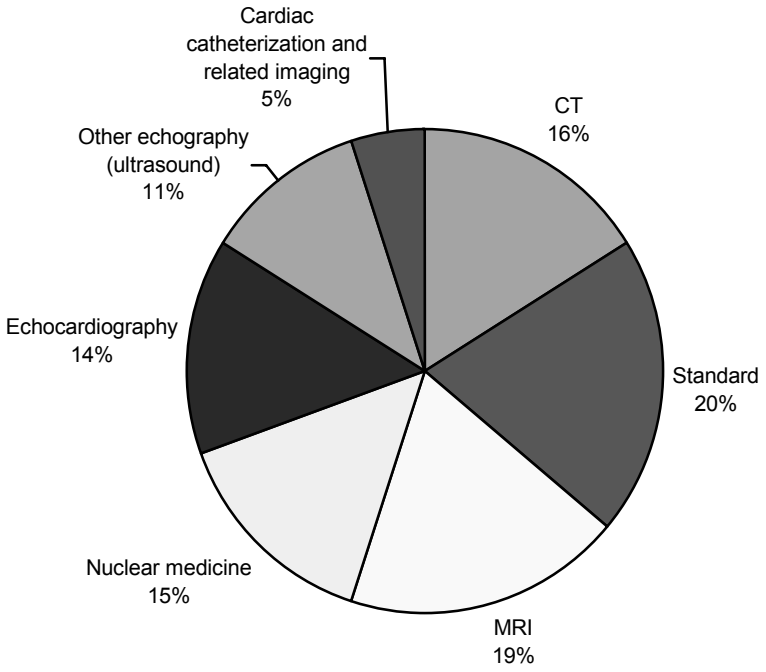
	1999	2000	2001	2002	2003	2004	2005
Medicare payments (billions of dollars)	$1.2	$1.4	$1.6	$1.9	$2.2	$2.5	$2.8
Number of centers	2,786	3,028	3,371	3,597	3,887	4,136	4,506
New centers	162	295	446	309	365	315	467
Exiting centers	20	53	103	83	75	66	97
Net percent growth from previous year	5.4%	8.7%	11.3%	6.7%	8.1%	6.4%	8.9%
Percent of all centers that are:							
For profit	94	94	94	95	95	96	96
Nonprofit	6	6	5	5	5	4	4
Urban	89	88	88	87	87	87	87
Rural	11	12	12	13	13	13	13

Note: ASC (ambulatory surgical center), N/A (not available). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2005 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 1999–2005. Payment data from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are entities that only furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- Medicare uses a simple fee schedule to pay for ASC services. The fee schedule divides procedures into nine payment groups. CMS is required to implement a revised payment system no later than January 1, 2008.
- Total Medicare payments for ASC services are growing rapidly. Payments increased by 15.3 percent per year, on average, from 1999 through 2005.
- The number of Medicare-certified ASCs grew at an average annual rate of 8.3 percent from 1999 through 2005. Each year from 1999 through 2005, an average of 337 new Medicare-certified facilities entered the market, while an average of 71 closed or merged with other facilities.
- Most Medicare-certified ASCs are for-profit facilities and are located in urban areas.

Chart 8-17. Medicare spending for imaging services, by type of service, 2004



Note: CT (computed tomography), MRI (magnetic resonance imaging). Cardiac catheterization includes placement of the catheter and the related imaging procedure, such as an angiogram. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services.

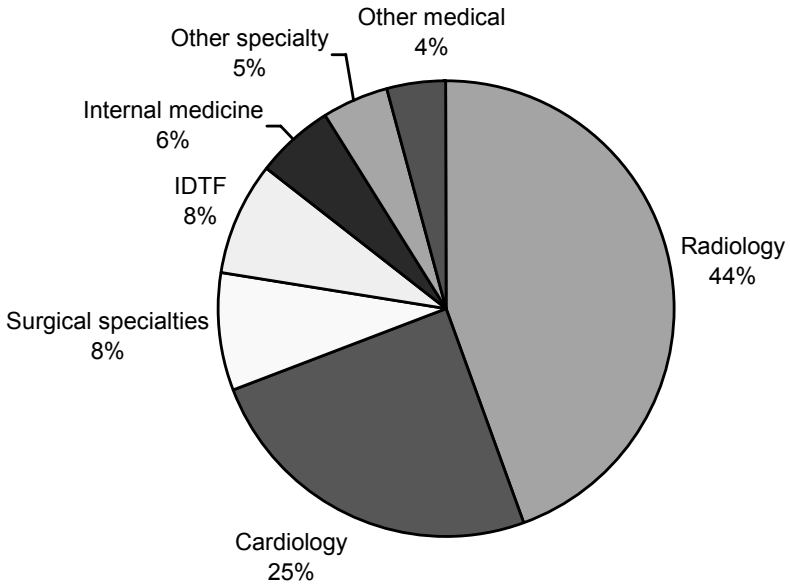
Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2004.

- Medicare spending for imaging services paid under the physician fee schedule nearly doubled between 1999 and 2004, from $5.7 billion to $10.9 billion.

- The volume and complexity of imaging services grew by 9.9 percent per year, on average, between 1999 and 2003—nearly twice as fast as all physician services (5.4 percent per year). Imaging increased 11 percent from 2003 to 2004. These growth rates are adjusted for increases in the number of fee-for-service beneficiaries and changes in payment rates.

- Spending for MRI, CT, and nuclear medicine has grown faster than for other imaging services. Thus, these categories represent an increasing share of total imaging spending. MRI spending grew by 162 percent between 1999 and 2004, nuclear medicine by 145 percent, and CT by 118 percent.

Chart 8-18. Radiologists received almost half of Medicare payments for imaging services, 2004



Note: IDTF (independent diagnostic testing facility). Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Total fee schedule imaging spending was $10.9 billion in 2004. Other specialty includes otolaryngology, pain management, osteopathic, physical medicine, nephrology, podiatry, cardiac surgery, oncology, and portable x-ray supplies.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2004.

- Imaging services paid under the physician fee schedule involve two parts: the technical component, which covers the cost of the equipment, supplies, and nonphysician staff, and the professional component, which covers the physician's work in interpreting the study and writing a report. A physician who both performs and interprets the study submits a global bill, which includes the technical and professional components.

- Independent diagnostic testing facilities (IDTFs) are independent of a hospital and physician office and only provide outpatient diagnostic services. IDTFs' share of Medicare imaging payments grew by 6 percent from 2003 to 2004. Medicare pays for IDTF services under the physician fee schedule at the same rates as services provided in physician offices.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_physician.pdf

- Chapter 2B of the MedPAC March 2006 Report to the Congress and Appendix A of the June 2006 Report to the Congress provide additional information on physician services.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02b.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_AppA.pdf

- More information on physician volume growth can be found in MedPAC's December 2004 report.

  http://www.medpac.gov/publications/congressional_reports/Dec04_PhysVolume.pdf

- Congressional testimony by the Chairman and Executive Director of MedPAC on February 10, 2005, March 17, 2005, and November 17, 2005, discusses payment for physician services in the Medicare program, including imaging.

  http://www.medpac.gov/publications/congressional_testimony/021005_WM_testimony.pdf

  http://www.medpac.gov/publications/congressional_testimony/031705_TestimonyImaging-Hou.pdf

  http://www.medpac.gov/publications/congressional_testimony/Testimony_111705_Phys_Pay.pdf

- The 2006 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.hhs.gov/ReportsTrustFunds/

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_OPD.pdf

- Section 2A of the MedPAC 2006 Report to the Congress provides information on the current status of "hold-harmless" payments and other special payments for rural hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_ASC.pdf

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf

SECTION 9

Post-acute care

Skilled nursing facilities
Home health agencies
Long-term care hospitals
Inpatient rehabilitation facilities

Chart 9-1. The number of post-acute care providers generally continues to grow

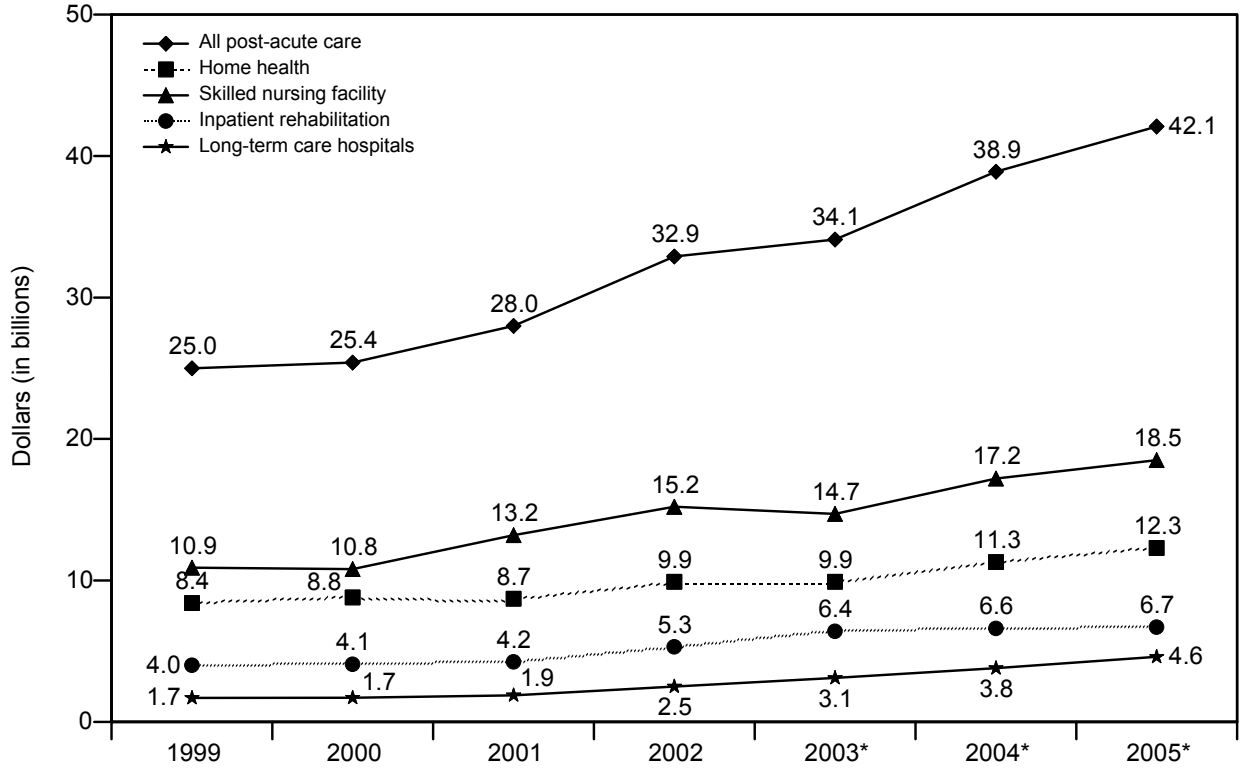
	1996	1998	2000	2002	2004	2005	Percent change 1996–2005
Skilled nursing facilities*	14,548	16,079	16,275	15,089	15,784	15,625	7.4%
Home health agencies	9,808	9,284	7,317	6,888	7,148	8,082	–17.6
Inpatient rehabilitation facilities	1,031	1,078	1,102	1,181	1,206	1,235	19.8
Long-term care hospitals	183	209	240	286	307	375	105.0

Note: *Includes swing bed hospitals.

Source: Online Survey, Certification, and Reporting system from CMS.

- The number of most types of post-acute care providers increased from 1996 to 2005.
- The number of home health agencies reached its peak in 1996 and then dropped. This may be due to many factors, including the interim payment system, increased program integrity scrutiny, and surety bond requirements. The number has begun to increase again in the most recent periods, climbing 17 percent between 2002 and 2005.
- Inpatient rehabilitation facilities increased by 20 percent from 1996 to 2005.
- The number of long-term care hospitals doubled from 1996 to 2005.

Chart 9-2. Spending for post-acute care has risen in each setting, 1999–2005



Note: These numbers are program spending only, and do not include beneficiary copayments.
*Estimated by CMS.

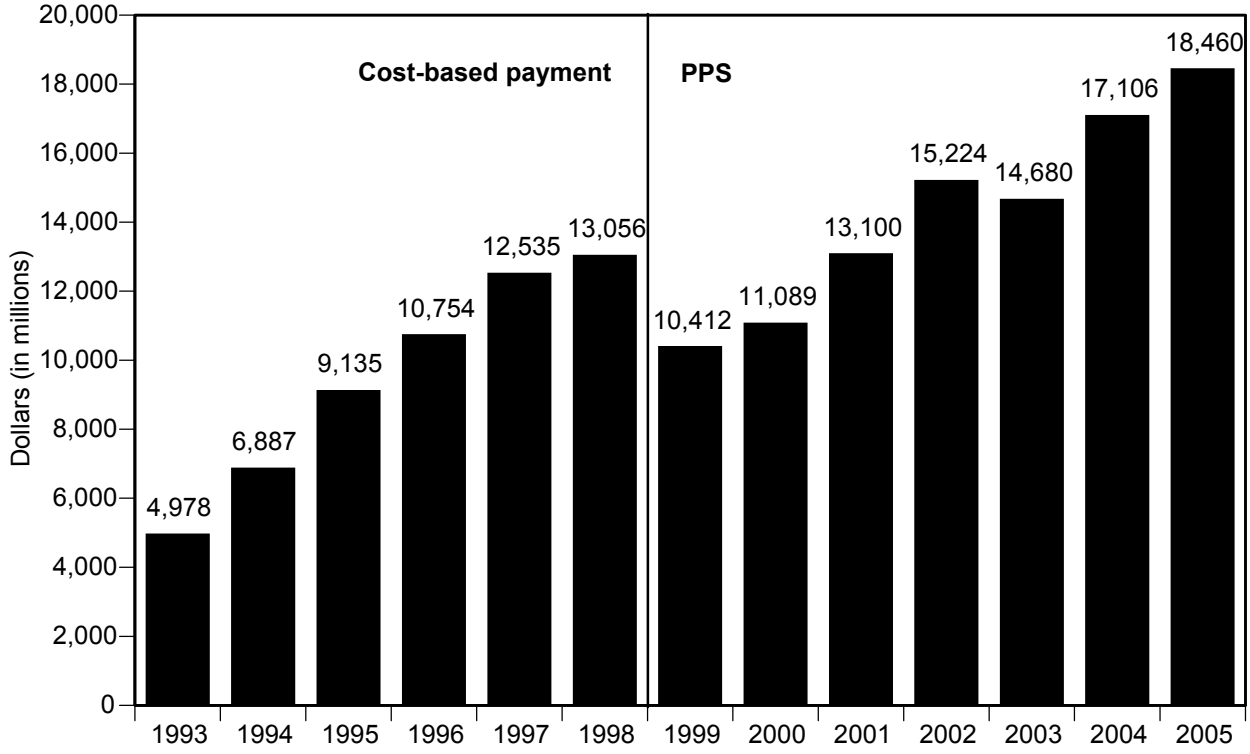
Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

- Medicare has prospective payment systems (PPSs) for the four post-acute care settings. CMS implemented these PPSs at the following times: skilled nursing facilities, July 1998; home health agencies, October 2000; inpatient rehabilitation facilities, January 2002; and long-term care hospitals, October 2002. Although CMS intended to use these payment systems to control Medicare spending for post-acute care, spending has increased an average of 7 percent per year since 1999.

- From 1999 through 2005, Medicare spending for long-term care hospitals has increased the most—at 18 percent per year. During the same period, spending for both skilled nursing facilities and inpatient rehabilitation facilities increased 9 percent per year, and spending for home health agencies increased 7 percent per year. For 2005, CMS estimated that total spending for post-acute care was $42 billion.

- Post-acute care currently makes up about 13 percent of Medicare's total spending.

Chart 9-3. Medicare spending for SNF services generally has increased but growth has moderated since the PPS was implemented



Note: Skilled nursing facility (SNF), prospective payment system (PPS). Spending is program spending for the calendar year.

Source: CMS, Office of the Actuary, 2006.

- Medicare program spending on skilled nursing facility (SNF) services grew an average of 21 percent per year from 1993 through 1998, when Medicare paid SNFs based on their costs, subject to some limits.

- In 1999, immediately following the implementation of the SNF prospective payment system, Medicare program spending on SNF services fell from $13.1 billion to $10.4 billion.

- Between 2000 and 2005, SNF spending grew at a slower rate than before the prospective payment system (PPS), but still averaged 11 percent per year for the period. Factors contributing to the growth during this period include increases in the use of services and increases in the payment rates over the period. Payment rate changes occurred because of annual updates; market basket forecast error correction; and temporary payment add-ons, some of which expired in fiscal year 2003 and some of which expired in January 2006 (year not shown) when CMS changed the patient classification system.

Chart 9-4. Medicare skilled nursing facility use increased between 1999 and 2003

Year	Number of admissions (thousands)	Number of days (millions)	Days per admission
1999	1,796	42.4	23.6
2000	1,824	43.8	24.0
2001	1,950	47.9	24.6
2002	2,223	54.7	24.6
2003	2,385	59.4	24.9
Average annual increase	7%	9%	1%

Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

Source: Skilled nursing facility Medicare Provider Analysis and Review stay records from CMS, Office of Research, Development, and Information.

- The number of Medicare admissions to skilled nursing facilities (SNFs) grew at an average annual rate of 7 percent between 1999 and 2003. Increased SNF use exceeds the rate of growth in the Medicare population; during this same period the average annual increase in the number of Part A enrollees was 1.2 percent.

- The number of SNF admissions increased 7 percent between 2002 and 2003, the most recent years for which we have data. Similarly, the number of SNF days increased 9 percent between 2002 and 2003.

Chart 9-5. Characteristics of skilled nursing facilities, 2003

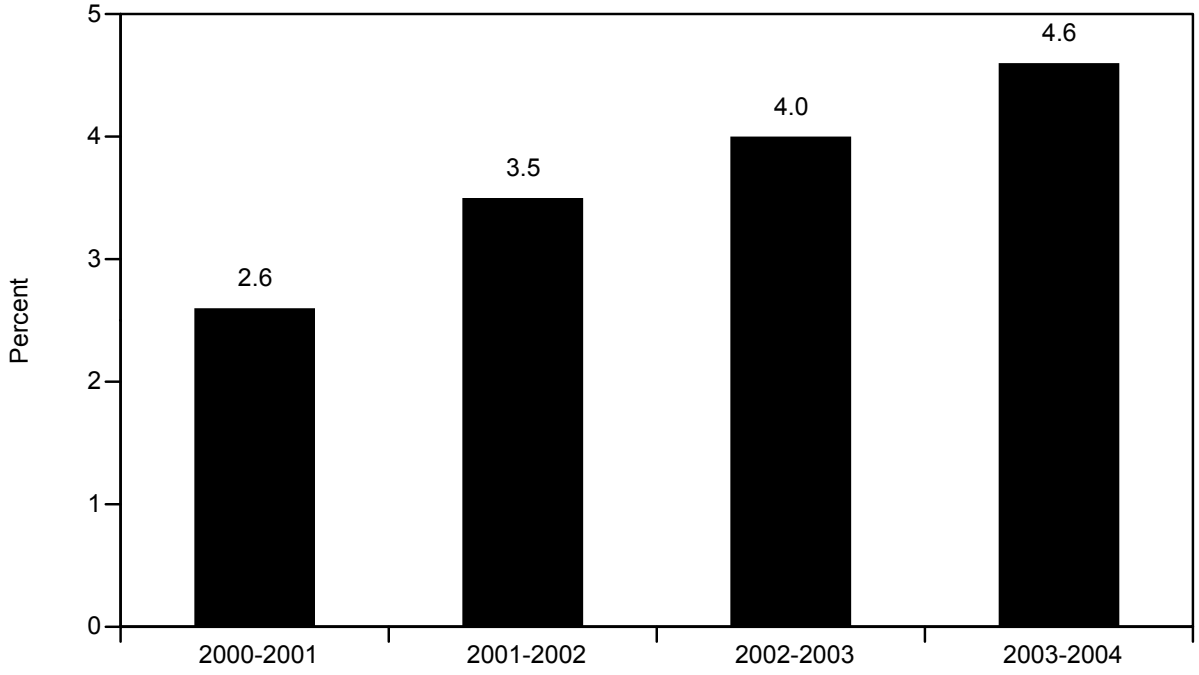
Type of SNF	Facilities	Medicare payments	Medicare-covered stays
Freestanding	90%	90%	83%
Hospital-based	10	10	17
Urban	67	81	78
Rural	33	19	22
Large chain	15	20	17
Not large chain	85	80	83
For profit	67	71	64
Nonprofit	28	26	31
Government	5	3	4

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of the Provider of Services file and 2003 Medicare Provider Analysis and Review file.

- Skilled nursing facility (SNF) services may be provided in freestanding or hospital-based facilities. In 2003, 90 percent of facilities were freestanding, and 83 percent of Medicare-covered SNF stays were in freestanding facilities.
- In 2003, 67 percent of SNFs were for profit. Similarly, a majority of Medicare SNF stays (64 percent) were in for-profit facilities.

Chart 9-6. Medicare costs per day in freestanding SNFs grew at an average annual rate of 3.7 percent between 2000 and 2004



Note: SNF (skilled nursing facility). Medicare per day cost growth was calculated from year to year among the cohort of freestanding SNFs with cost report data in all five years. Cost per day is not adjusted for differences in case mix.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Per-day costs for Medicare beneficiaries in freestanding skilled nursing facilities (SNFs) grew, on average, 3.7 percent annually between 2000 and 2004, with the most recent period seeing a higher rate of growth.
- During this same period, for-profit facilities had lower average annual cost growth (3.5 percent) than nonprofit (4.4 percent) or government facilities (4.5 percent).
- For the least costly SNFs (those at the 25th percentile), average annual per day Medicare cost growth was 1 percent, while for the most costly SNFs (those at the 75th percentile), it was 7.2 percent.

Chart 9-7. Freestanding skilled nursing facility Medicare margin, by facility group, 2004

Facility type	Facilities	Medicare margin
All facilities	11,049	13.5%
Urban	7,606	12.8
Rural	3,432	16.6
Large chain	2,043	18.2
Not large chain	9,006	12.0
For profit	8,374	16.1
Nonprofit	2,304	3.8
Government	371	–1.1

Note: Eleven facilities had missing urban or rural designations.

Source: MedPAC analysis of Medicare cost report and Provider of Service file from CMS.

- Based on 2004 cost report data, we estimate that the 2006 aggregate Medicare margin for freestanding skilled nursing facilities (SNFs) is 9.4 percent. Nonprofit facilities had lower margins (3.8 percent) than for-profit facilities (16.1 percent) in 2004.
- Our projected margin for 2006 is 9.4 percent.

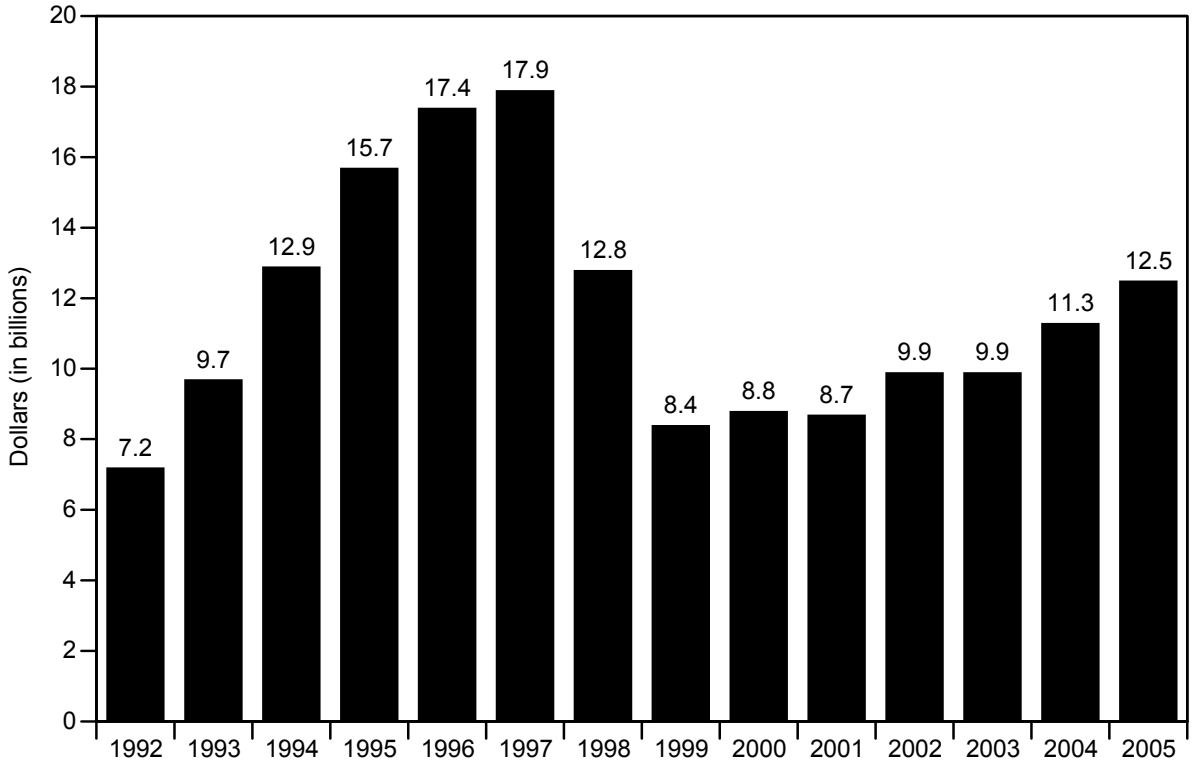
Chart 9-8. The highest percentage of Medicare-covered freestanding SNF days were in "very high" and "high" rehabilitation RUG–III groups in 2004

RUG–III group	Percent of Medicare days
Rehabilitation	**79.7%**
Ultra high, 16–18 ADL	2.3
Ultra high, 9–15 ADL	7.2
Ultra high, 4–8 ADL	1.9
Very high, 16–18 ADL	4.0
Very high, 9–15 ADL	16.8
Very high, 4–8 ADL	5.5
High, 13–18 ADL	14.7
High, 8–12 ADL	10.9
High, 4–7 ADL	3.9
Medium, 15–18 ADL	4.3
Medium, 8–14 ADL	6.0
Medium, 4–7 ADL	2.1
Low, 14–18 ADL	0.1
Low, 4–13 ADL	0.2
Extensive services	**6.5**
7–18 ADL, 4–5 services	2.9
7–18 ADL, 2–3 services	3.4
7–18 ADL, 0–1 services	0.2
Special care	**5.4**
17–18 ADL	1.3
15–16 ADL	1.7
7–14 ADL	2.4
Clinically complex	**6.0**
17–18 ADL, depression	0.2
17–18 ADL, no depression	0.6
12–16 ADL, depression	0.6
12–16 ADL, no depression	1.9
4–11 ADL, depression	0.7
4–11 ADL, no depression	2.0
Nonskilled RUGs	**2.2**
Unknown RUG	0.2

Note: SNF (skilled nursing facility), RUG–III (resource utilization group, version III), ADL (activity of daily living). Total percent may not add to 100 due to rounding. ADLs are expressed in terms of an index. The higher the index, the greater the patient's limitation on activities of daily living. "Services" is a count of the services or conditions that qualify a beneficiary for the extensive services category. The greater the number of services, the greater the anticipated resource use within the extensive services category.

Source: MedPAC analysis of Medicare cost report data from CMS.

Chart 9-9. Spending for home health care, 1992–2005



Note: In 2004, the payment system changed from fiscal year to calendar year.

Source: CMS, Office of the Actuary, 2006.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.
- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continues at the regional home health intermediaries and survey and certification units.
- Since 2001, the number of users, the number of episodes, and the amount of spending have increased.

Chart 9-10. Medicare home health care use, 1992–2003

Year	People served	Visits	
	Number (thousands)	Number (millions)	Per person served
1992	2,506	132	53
1993	2,874	164	57
1994	3,179	209	66
1995	3,469	249	72
1996	3,600	265	74
1997	3,558	258	73
1998	3,062	155	51
1999	2,720	113	42
2000	2,461	91	37
2001	2,403	71	31
2002	2,544	73	31
2003	2,681	75	31

Source: CMS, Office of the Actuary, May 2005.

- In the early 1990s, the rapid growth in home health use was a concern to policymakers. Between 1992 and 1996, the number of beneficiaries using home health care increased by more than one million. The total volume of home health was expanding rapidly as the number of visits per user increased along with the number of users.

- In the mid-1990s, the Congress required home health agencies to begin the transition to a prospective payment system, CMS clarified the standards of eligibility for the home health benefit, and the Office of Inspector General increased its scrutiny of home health. Between 1997 and 2000, the number of users fell by one million.

Chart 9-11. The home health product changed after the prospective payment system started

	1997	2002
Average visits per episode	36	19
Average minutes per episode	1,500	940
Percent therapy visits	9%	26%

Note: The prospective payment system (PPS) began in October 2000.

Source: Pre-PPS CMS analysis of the National Claims History file; post-PPS MedPAC analysis of 5 percent Standard Analytic File.

- The types and quantity of home health care services that beneficiaries receive are changing. In 1997, before the PPS, the average number of visits per episode was 36. By 2002, that had fallen to 19 visits. The average length of stay fell from 106 days in 1997 to 56 days in 2002.

- The mix of visits (therapy, aide, or skilled visits as a percent of total visits provided during an episode) has shifted toward therapy (physical therapy, occupational therapy, and speech pathology) and away from home health aide services. The home health payment system rewards the provision of therapy services (physical, occupational, or speech). Meeting the therapy threshold for a payment episode produces substantially higher payments for otherwise similar patients. For example, an episode for a patient with moderate clinical severity and moderate functional limitation would be paid $2,440 (base payment × case weight 1.08) if the episode did not meet the therapy threshold and $4,420 (base payment × case weight 1.95) if the episode did meet the therapy threshold.

- Information about the use of home health services after the PPS can be found on the CMS website, available at http://www.medicare.gov.

Chart 9-12. Aggregate Medicare margins for all freestanding home health agencies remain in double digits, 2004

Agency group	Number of agencies	2004 margin
All agencies	3,979	16.0%
Caseload		
Urban	2,546	15.9
Mixed	985	17.0
Rural	448	11.8
Type of control		
Voluntary	686	12.4
Private	3,047	18.1
Government	246	8.1
Volume group, lowest to highest		
First quintile	843	13.1
Second quintile	781	10.5
Third quintile	794	12.9
Fourth quintile	792	15.9
Fifth quintile	769	17.5

Note: Some freestanding agencies were omitted because of data integrity concerns.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- In 2004, 80 percent of agencies had positive margins. These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).
- Our projected 2006 margin is 14.7 percent.
- These margins are for freestanding HHAs, which composed two-thirds of all HHAs in 2001. Home health agencies are also based in hospitals and other facilities.

Chart 9-13. The top 15 LTC–DRGs in 2004 made up almost two-thirds of LTCH discharges

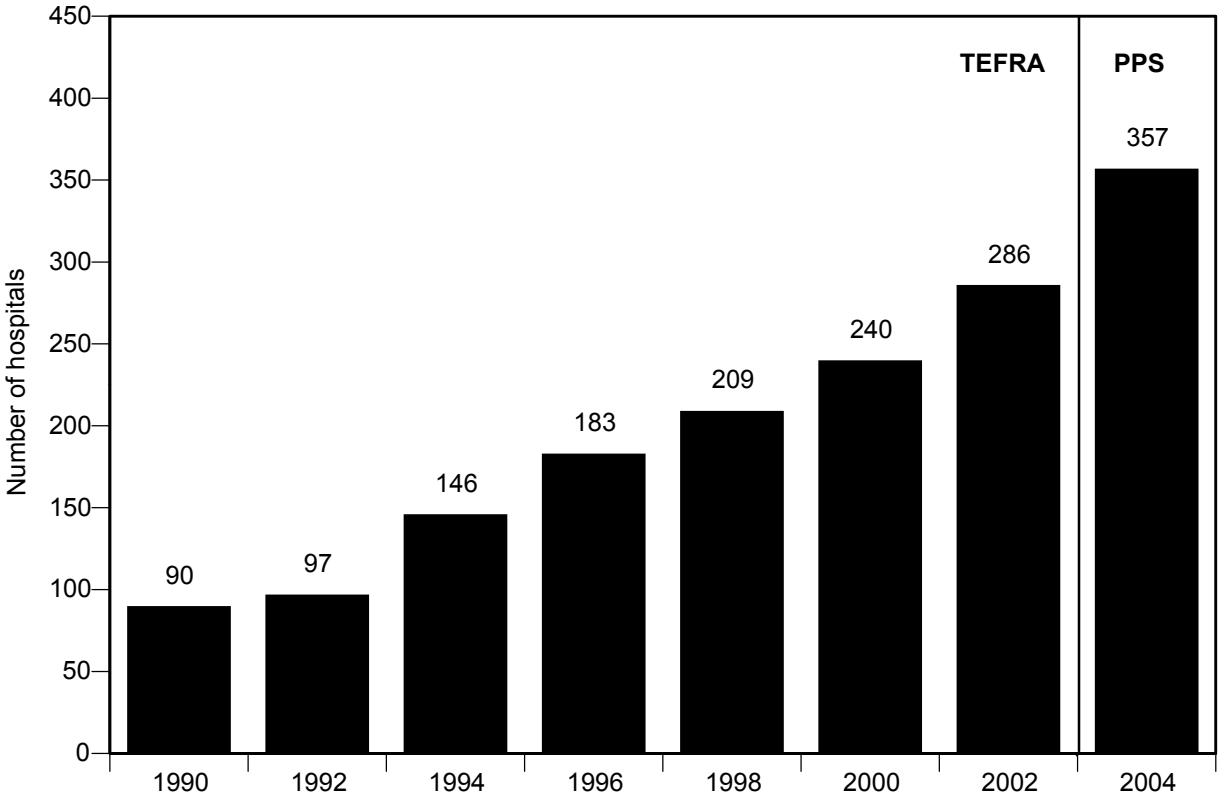
LTC–DRG	Description	Discharges	Percentage
475	Respiratory system diagnosis with ventilator support	13,007	10.6%
249	Aftercare, musculoskeletal system and connective tissue	6,212	5.1
12	Degenerative nervous system disorders	5,802	4.7
271	Skin ulcers	5,594	4.6
462	Rehabilitation	5,072	4.1
88	Chronic obstructive pulmonary disease	4,980	4.1
87	Pulmonary edema and respiratory	4,960	4.1
89	Simple pneumonia and pleurisy with CC	4,826	3.9
466	Aftercare without history of malignancy as secondary diagnoses	4,497	3.7
79	Respiratory infections and inflammations with CC	4,449	3.6
416	Septicemia	4,144	3.4
263	Skin graft and/or debridement for skin ulcer with CCs	3,739	3.1
127	Heart failure and shock	3,699	3.0
316	Renal failure	2,360	1.9
430	Psychoses	2,355	1.9
	15 LTC–DRGs	75,696	61.9
	Total discharges	122,320	100.0

Note: LTC–DRG (long-term care diagnosis related group), LTCH (long-term care hospital), CC (complication or comorbidity).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Long-term care hospitals (LTCHs) treat beneficiaries with diverse diagnoses. Five of the top 15 diagnoses in LTCHs are related to respiratory conditions.
- The most frequent diagnosis for LTCHs is for patients on ventilator support. These beneficiaries make up almost 11 percent of all Medicare LTCH patients.

Chart 9-14. The number of long-term care hospitals has grown rapidly since 1990



Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service file from CMS.

- The number of long-term care hospitals (LTCHs) quadrupled between 1990 and 2004.
- The number of LTCHs increased 10 percent annually during this period.

Chart 9-15. Volume of cases and Medicare spending increased under the LTCH prospective payment system

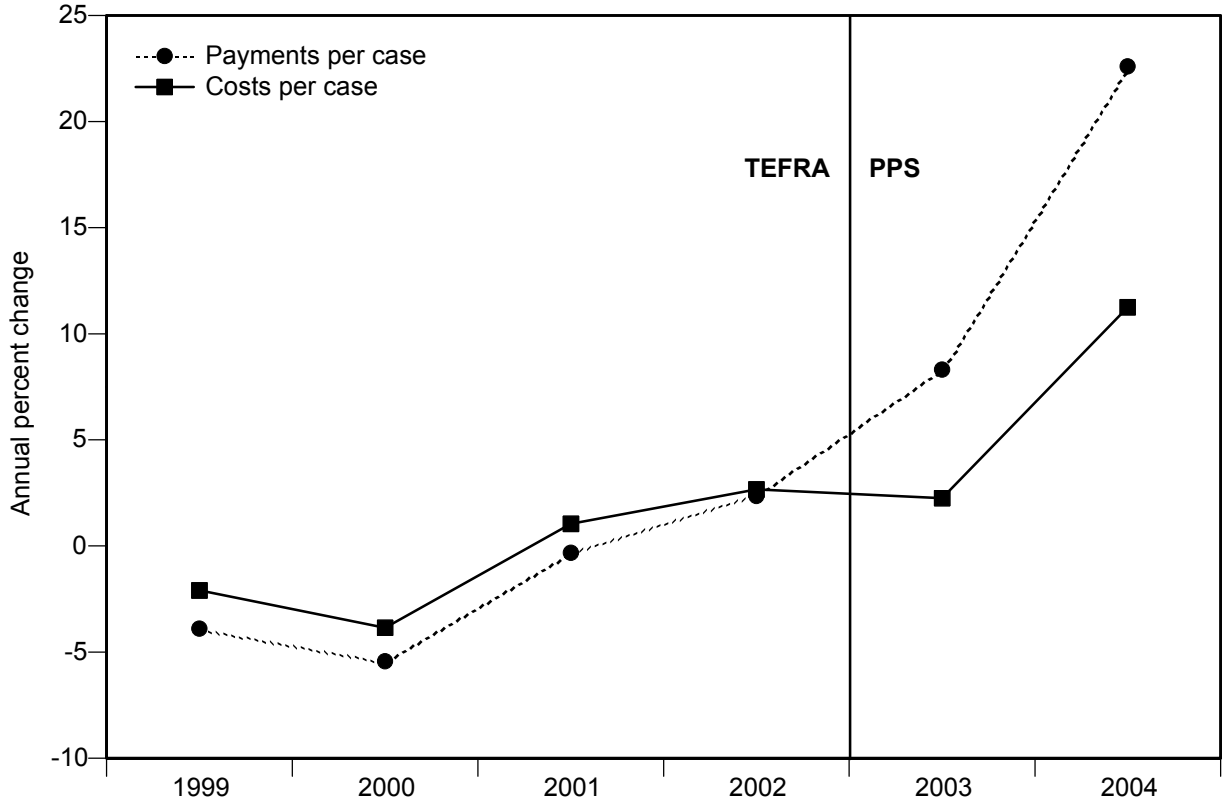
	TEFRA	PPS		Average annual change
	2001	2003	2004	2001–2004
Number of cases	86,049	110,509	122,320	12%
Medicare spending	$1.7 billion	$2.4 billion	$3.3 billion	25
Payment per case	$22,452	$25,076	$30,180	10
Length of stay (in days)	32.1	29.2	28.7	–4

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of MedPAR data from CMS.

- The number of beneficiaries discharged from long-term care hospitals (LTCHs) increased 12 percent annually from 2001 to 2004.
- From 2001 to 2004, Medicare spending for long-term care hospitals increased 25 percent per year. In the last year alone, Medicare spending for these facilities increased 38 percent.
- From 2001 to 2004, Medicare's payment per case increased 10 percent annually while length of stay, usually positively associated with costs per case, decreased 4 percent.

Chart 9-16. Comparison of changes in LTCHs' Medicare payments and costs per case, 1999–2004



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of cost reports from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented in fiscal year 2003, long-term care hospitals' (LTCHs') Medicare per case costs and payments increased at similar rates. Under PPS, LTCHs' Medicare per case payments have increased much faster than their per case costs.

- These similarities and differences are reflected in LTCHs' Medicare margins, shown in Chart 9-17.

Chart 9-17. Long-term care hospitals' PPS Medicare margin, by group, 2003–2004

LTCH group	2003	2004
All LTCHs	5.4%	9.0%
Urban	5.5	9.0
Rural	0.8	8.6
Freestanding	5.2	8.7
HWHs	5.8	9.6
Nonprofit	1.6	6.0
For profit	6.7	10.3
Government	–1.9	–2.8

Note: LTCH (long-term care hospital), PPS (prospective payment system), HWH (hospital within hospital).

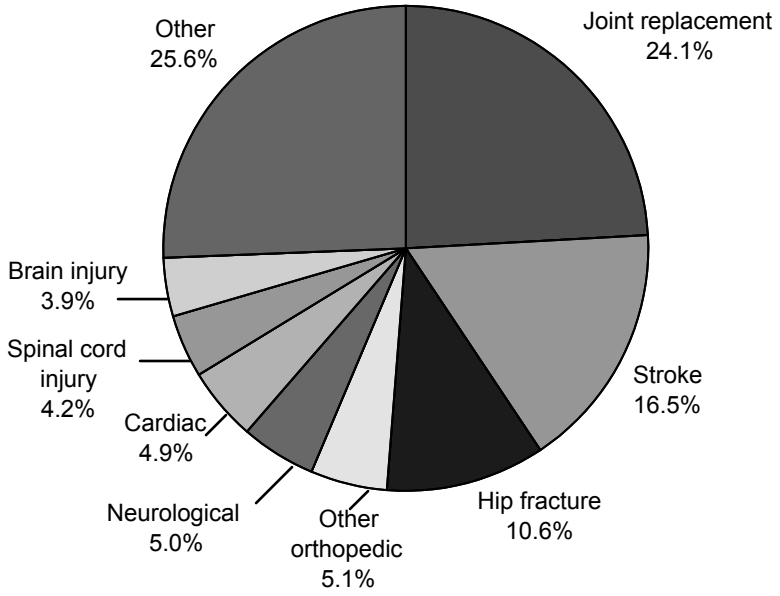
Source: MedPAC analysis of cost reports from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before long-term care hospitals' (LTCHs') prospective payment system (PPS) was implemented, these facilities' Medicare margins were close to zero, ranging from –1.7 to 0.4 percent. Under PPS, margins have increased rapidly, from 5.4 percent in 2003 to 9.0 percent in 2004.

- In 2004, urban, rural, freestanding, and hospital within hospital (HWH) LTCHs had similar Medicare margins—9.0, 8.6, 8.7, and 9.6 percent, respectively. There is greater variation in Medicare margins by ownership, with nonprofit LTCHs at 6 percent and for-profit LTCHs at 10.3 percent.

- Our projection of the 2006 margin is 7.8 percent.

Chart 9-18. Distribution of most common types of cases in inpatient rehabilitation facilities, 2004



Note: Other includes conditions such as amputation, pain syndrome, and pulmonary.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

- In 2004, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was joint replacement, representing 24.1 percent of cases, a smaller share of IRF cases than in 1996.
- Stroke was the second most frequent diagnosis in 2004, at 16.5 percent of cases. In 1996, stroke made up 19.6 percent of IRF cases.

Chart 9-19. The number of all types of inpatient rehabilitation facilities has grown

Type of IRF	TEFRA 2000	TEFRA 2001	PPS 2002	PPS 2003	PPS 2004	Change 2000–2001	Annual Change 2002–2004	Annual Change 2000–2004
All IRFs	1,117	1,157	1,188	1,211	1,227	4%	2%	2%
Urban	950	971	988	1,001	1,009	2	1	2
Rural	167	186	200	210	218	11	4	7
Freestanding	195	214	215	215	217	10	0	3
Hospital-based	922	943	973	996	1,010	2	2	2
Nonprofit	731	733	755	765	772	0	1	1
For profit	240	271	277	290	294	13	3	5
Government	146	153	156	156	161	5	2	2

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service information from CMS.

- Between 2000 and 2004, the number of inpatient rehabilitation facilities (IRFs) increased 2 percent per year, slightly faster than Medicare beneficiaries.
- Rural IRFs increased the fastest during this period, at 7 percent annually, while nonprofit IRFs increased the slowest, at 1 percent annually.

Chart 9-20. Volume of care and Medicare spending increased under the IRF prospective payment system

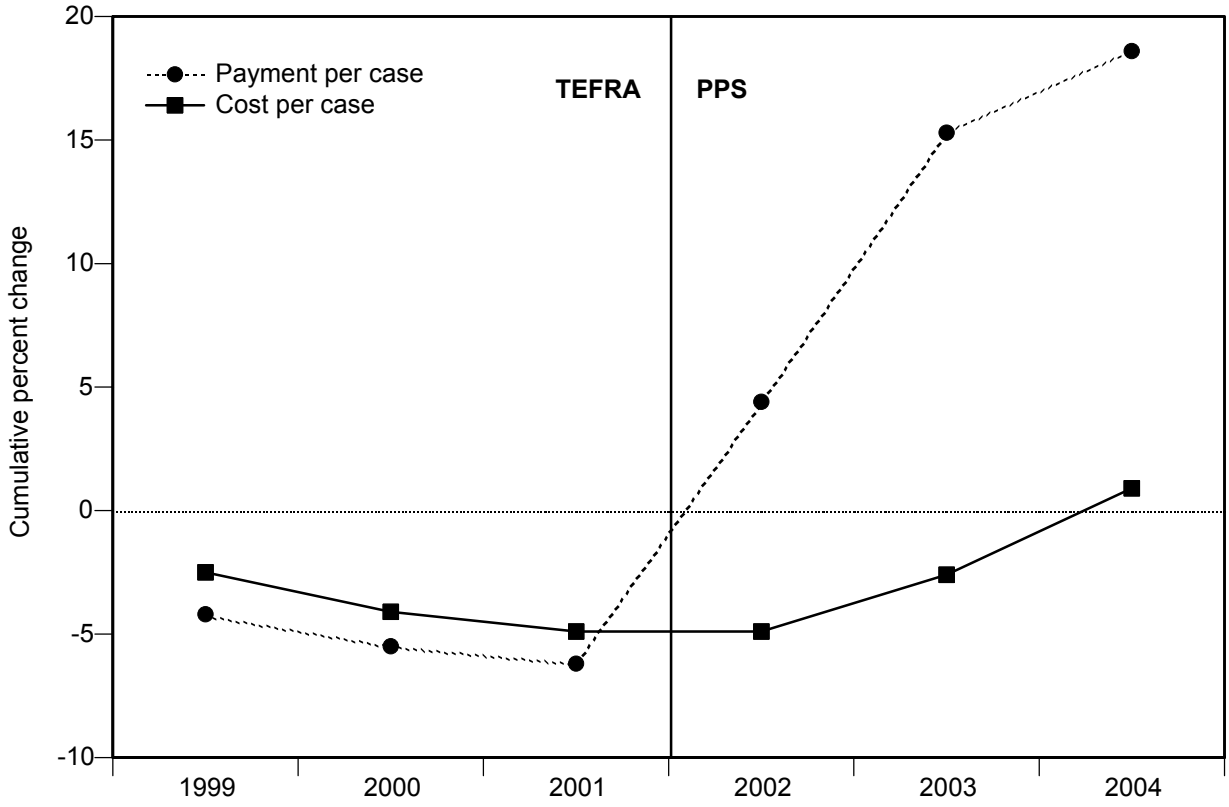
	TEFRA			PPS		
	2000	2001	Change 2000–2001	2002	2004	Average annual change 2002–2004
Number of cases	384,207	415,579	8%	438,631	496,695	6%
Medicare spending	$3.6 billion	$3.7 billion	3	$4.5 billion	$6.0 billion	15
Payment per case	$10,312	$9,982	–3	$11,152	$13,275	9
Length of stay (in days)	14.6	14.0	–4	13.3	12.7	–2

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- The number of Medicare beneficiaries discharged from inpatient rehabilitation facilities (IRFs) increased at a somewhat slower pace under the prospective payment system (PPS), at 6 percent per year, compared with an increase of 8 percent per year under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) during 2000 and 2001.
- Medicare spending increased at a much faster pace under the PPS, at 15 percent per year, compared with 3 percent per year under TEFRA during 2000 and 2001.
- Under PPS from 2002 to 2004, payment per case increased 9 percent per year, while length of stay, usually related to cost per case, decreased 2 percent per year.

Chart 9-21. IRFs' Medicare payments have risen faster than their costs, post-PPS



Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of IRFs.

Source: MedPAC analysis of cost report data from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented in 2002, inpatient rehabilitation facilities' (IRFs') Medicare per case costs and payments increased at similar rates. Under PPS, IRFs' Medicare per case payments have increased much faster than their per case costs.

- These similarities and differences are reflected in IRFs' Medicare margins, shown in Chart 9-22.

Chart 9-22. Inpatient rehabilitation facilities' PPS Medicare margins, by group, 2002–2004

IRF group	2002	2003	2004
All IRFs	11.1%	17.7%	16.3%
Urban	11.7	18.4	16.9
Rural	4.6	10.3	10.6
Freestanding	18.2	23.0	24.2
Hospital-based	6.7	14.6	12.0
Nonprofit	6.7	14.3	12.6
For profit	19.3	24.2	24.4
Government	1.0	9.5	8.6

Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).

Source: MedPAC analysis of cost report data from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented, these facilities' Medicare margins ranged from 1.1 percent to 2.9 percent. Under PPS, margins have increased rapidly, rising to 16.3 percent in 2004.

- In 2004, freestanding inpatient rehabilitation facilities (IRFs) have an aggregate margin that is twice that of hospital-based IRFs. Similarly, the aggregate margin of for-profit IRFs is almost double that of nonprofit IRFs.

- Our projection of the 2006 margin is 9.2 percent. In making this projection, we assumed that facilities will reduce patient volume by 25 percent in response to changes in the criteria for IRFs. Under less conservative assumptions, the Medicare margin could be 3 percentage points higher. With more conservative assumptions, the margin would be 2 percentage points lower.

Web links. Post-acute care

- Chapter 4 of MedPAC's March 2006 Report to the Congress and Chapter 5 of MedPAC's June 2005 Report to the Congress provide information on post-acute care.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04.pdf
  http://www.medpac.gov/publications/congressional_reports/June05_Ch5.pdf

Skilled nursing facilities

- Chapter 4A of MedPAC's March 2006 Report to the Congress, Chapter 2C of MedPAC's March 2005 Report to the Congress, and Chapter 3C of MedPAC's March 2004 Report to the Congress provide information on Medicare margins for skilled nursing facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04A.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02C.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3C.pdf

- The official Medicare website provides information on the prospective payment system and other related issues.

  http://www.cms.hhs.gov/snfpps/

Home health services

- Chapter 4B of MedPAC's March 2006 Report to the Congress provides information on home health services.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04B.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research, as well as information on home health spending and use of services.

  http://www.cms.hhs.gov/center/hha.asp

Long-term care hospitals

- Chapter 4C of MedPAC's March 2006 Report to the Congress and Chapter 5 of MedPAC's June 2004 Report to the Congress provide information on long-term care hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_ch04c.pdf
  http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://www.cms.hhs.gov/longtermcarehospitalpps/

Inpatient rehabilitation facilities

- Chapter 4D of MedPAC's March 2006 Report to the Congress provides information on inpatient rehabilitation facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04D.pdf

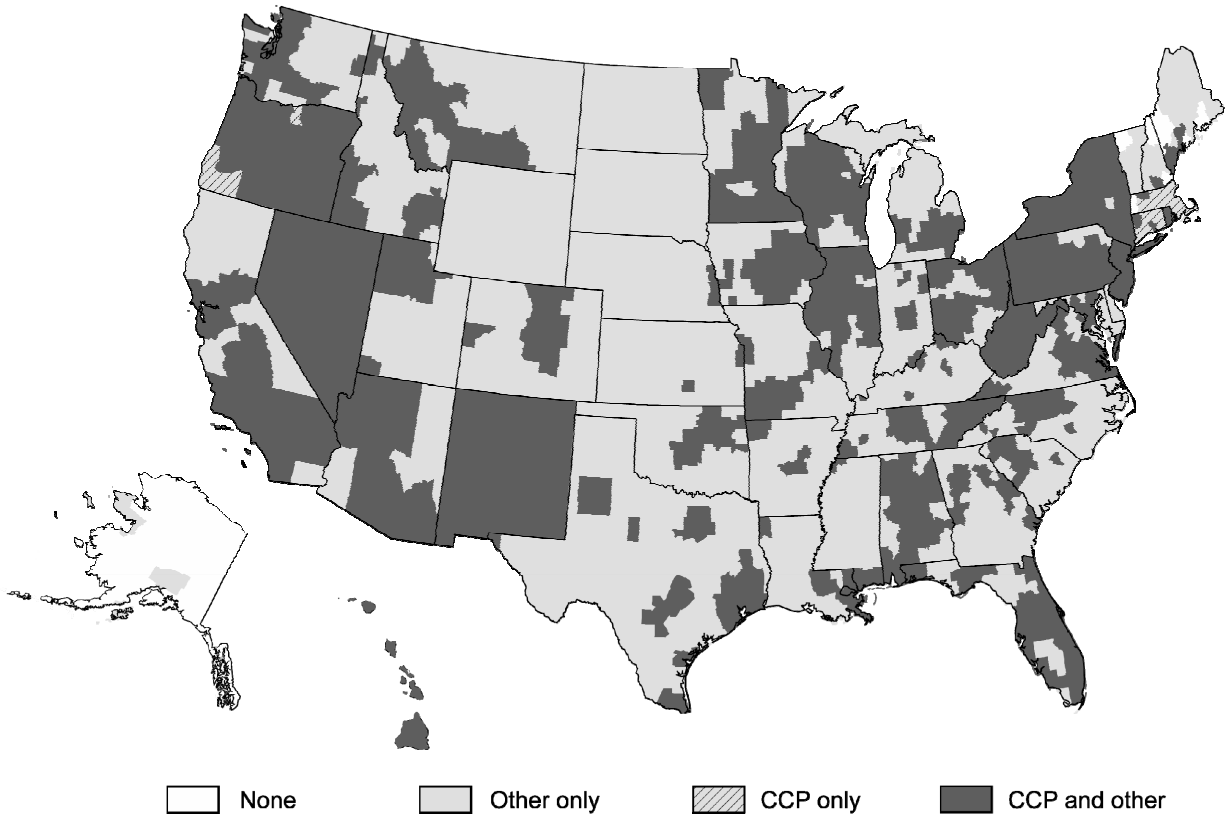
- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://www.cms.hhs.gov/InpatientRehabFacPPS

SECTION 10

Medicare Advantage

Chart 10-1. Counties with MA plans, 2006

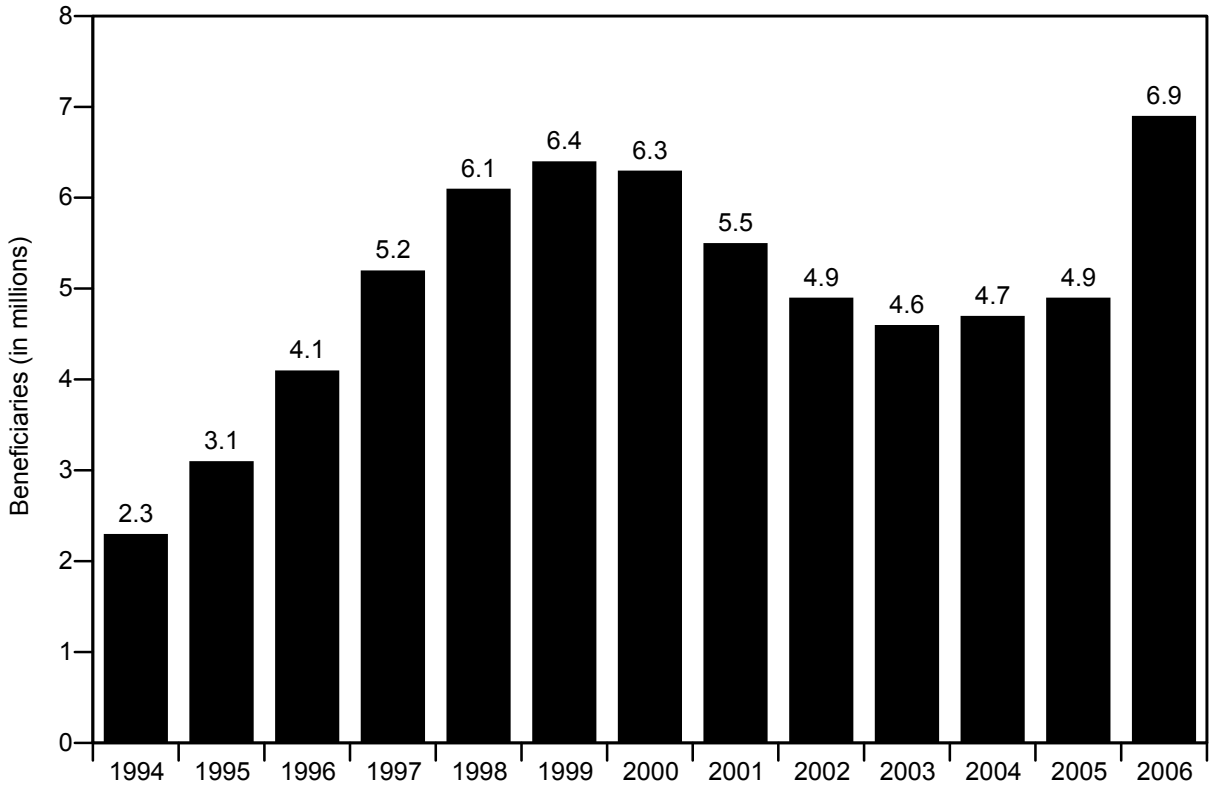


Note: MA (Medicare Advantage), CCP (coordinated care plan). Other includes private fee-for-service and regional preferred provider organizations.

Source: Medicare Health Plan Compare database, May 2006. Available at http://www.medicare.gov.

- Local coordinated care plans (CCPs) are local preferred provider organizations (PPOs) and health maintenance organizations (HMOs) which have comprehensive provider networks and limit or discourage use of out-of-network providers. Other types of Medicare Advantage (MA) plans are private fee-for-service (PFFS) plans and regional PPOs. PFFS plans are not required to have any networks and members may go to any willing Medicare provider. Regional PPOs cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Regional PPOs are available beginning in 2006.
- MA plans are available in at least parts of all states. Local CCPs are available in 45 states, and other MA plans are available in all 50 states.
- Local CCPs are available to 80 percent of Medicare beneficiaries in 2006—up from 67 percent in 2005. Other MA plans are available to 95 percent of beneficiaries—up from 45 percent in 2005. Overall, almost 100 percent of beneficiaries live in a county where MA plans are available in 2006—up from 84 percent in 2005.
- MA plans that include the Medicare Part D prescription drug benefit are available to 99 percent of all Medicare beneficiaries.
- These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process. More specifically, special needs plans, cost-based plans, employer-only plans, and certain other demonstration plans are excluded.

Chart 10-2. Enrollment in MA plans, 1994–2006

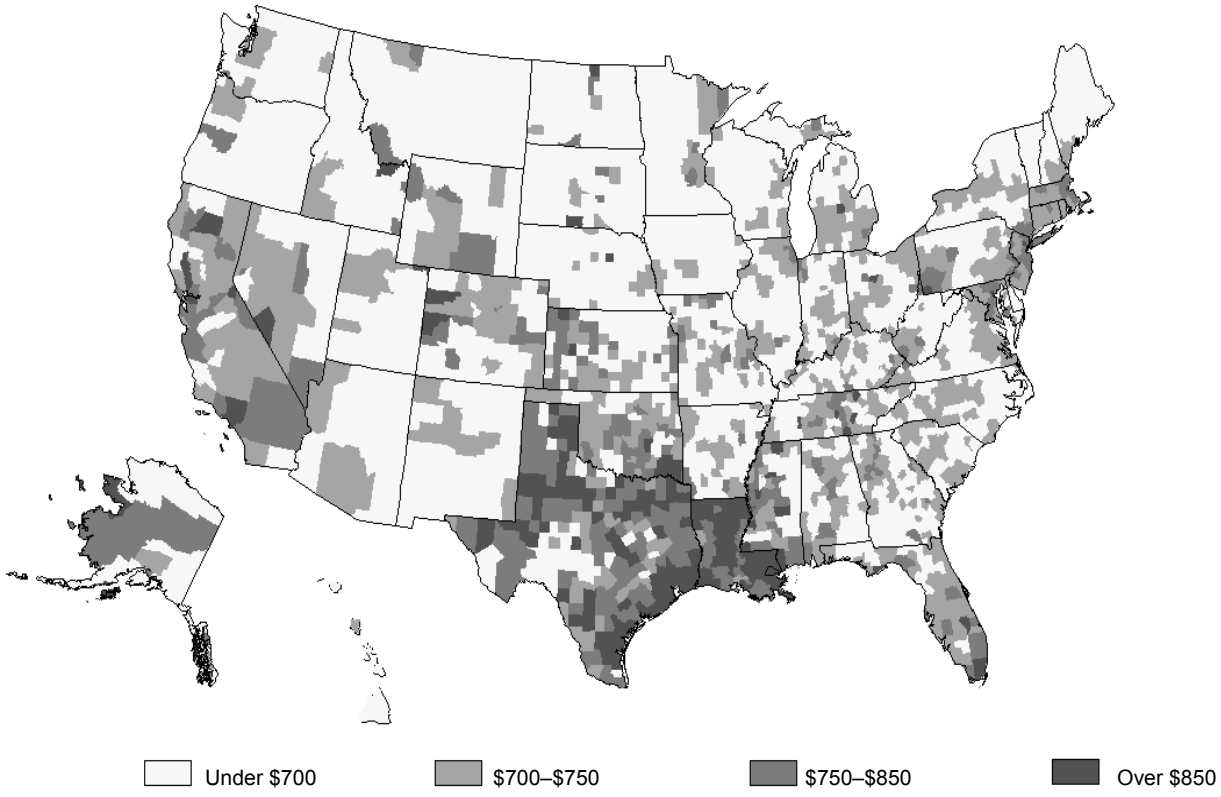


Note: MA (Medicare Advantage).

Source: Medicare Managed Care Contract (MMCC) Plans, Monthly Summary Reports, CMS.

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 6.9 million enrollees. Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999 (17 percent of all Medicare beneficiaries), and declined steadily to a low of 4.6 million enrollees in 2003 (12 percent of all Medicare beneficiaries).

Chart 10-3. County benchmarks for MA plans, 2006



Note: MA (Medicare Advantage).

Source: CMS website, 2006.

- Benchmarks are bidding targets that CMS sets for every county as directed by law. The 2006 benchmarks are the 2005 Medicare Advantage (MA) county payment rates, updated by the projected national growth rate in per capita Medicare spending.
- Plans submit bids for the basic Medicare benefit which are compared with the benchmark. If the bid is higher than the benchmark, the plan is paid the benchmark and the members pay the difference with a premium. However, if the bid is below the benchmark, the plan is paid its bid plus 75% of the difference and the remaining 25% of the difference is retained by the Medicare program. The plan is then obligated to rebate its share of the difference to its members in the form of supplemental benefits or reduced premiums.
- In 2006, Medicare payment rates (standardized for health risk) for MA plans in U.S. counties range from $670 to $1,207 per month.
- The counties with benchmarks under $700 per month contain 22 percent of Medicare beneficiaries.
- The counties with benchmarks between $700 and $750 contain 43 percent of Medicare beneficiaries.
- The counties with benchmarks between $750 and $850 contain 23 percent of Medicare beneficiaries.
- The counties with benchmarks above $850 contain 12 percent of Medicare beneficiaries.

Chart 10-4. Benefits available to beneficiaries in MA plans, by type of plan

	Local plans				
	HMO	PPO	PFFS	Regional PPO	Any MA plan
Prescription drug plans	72%	63%	70%	88%	99%
Zero-premium prescription drug plans	48	11	25	15	68
Out-of-pocket limit:					
$5,000 or less	53	41	75	88	98
$2,000 or less	28	16	37	4	65
Cost sharing for 6-day hospital stay, $500 or less	63	45	43	13	87

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: CMS 2006 unpublished bid data.

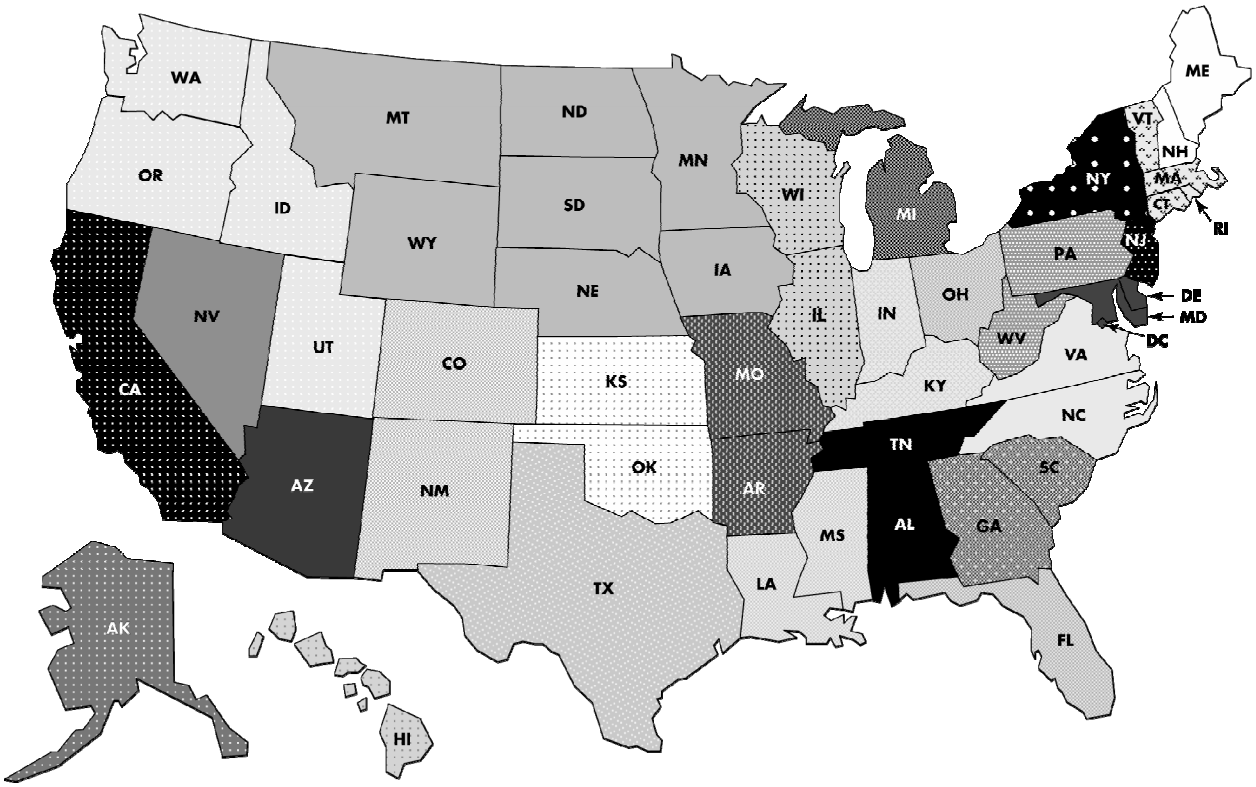
- Ninety-nine percent of Medicare beneficiaries have a Medicare Advantage (MA) plan available that includes the Part D prescription drug benefit—an MA–PD. The most widely available type of MA–PD is the regional PPO, which is available to 88 percent of Medicare beneficiaries.

- Zero-premium MA–PDs are available to 68 percent of beneficiaries. In a zero-premium MA–PD, enrollees do not have to pay an extra premium (above the standard Part B premium) to join the plan, and there is no Part D premium. Local HMOs are the most widely available zero-premium MA–PDs.

- Overall, 98 percent of beneficiaries have access to a plan that includes an annual out-of-pocket (OOP) limit of $5,000 or less, and 65 percent of beneficiaries have a plan available that includes an OOP limit of $2,000 or less. Private fee-for-service plans with an OOP limit no higher than $2,000 are available to 37 percent of beneficiaries. Also, HMOs with OOP limits of $2,000 or lower are available to 28 percent of Medicare beneficiaries, and local PPOs with these limits are available to 16 percent. We note that many plans charge low enough cost sharing that enrollees in such plans are unlikely to reach these levels of OOP spending.

- Eighty-seven percent of Medicare beneficiaries have access to a plan with expected cost sharing of $500 or less for a six-day inpatient hospital stay. Availability of these plans is greater for HMOs and other local plans. Only 13 percent of beneficiaries have access to a regional PPO with this level of cost sharing.

Chart 10-5. MA Regions



Note: MA (Medicare Advantage).

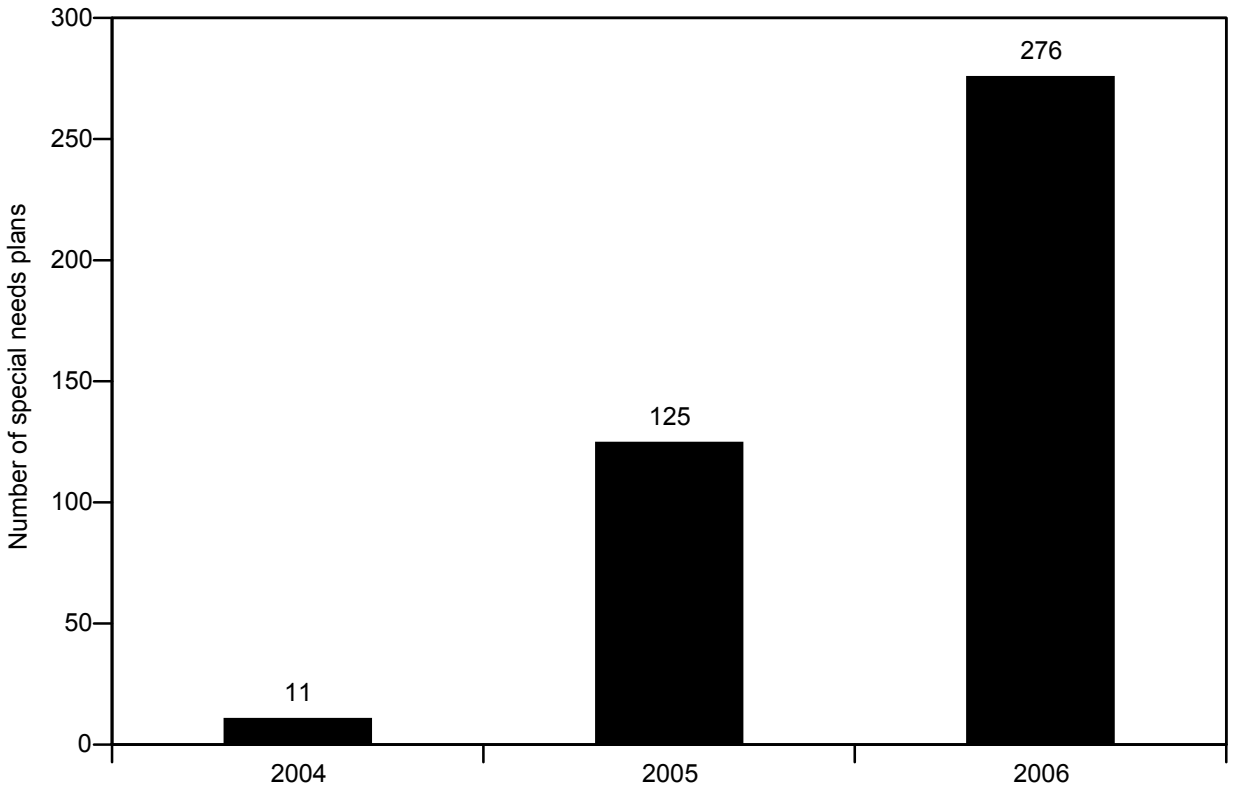
Source: CMS website, 2006. http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/MAPDRegions.pdf.

- In 2006, regional preferred provider organizations (PPOs)—which must cover entire state-based regions—are offered in the Medicare Advantage program. Regional PPOs must have PPO-like networks, which may sometimes be looser than the ones required of local PPOs.

- CMS chose 26 PPO regions based on factors including population size, sufficient numbers of existing competitors, and preservation of geographic patient flows.

- In 2006, there are regional PPOs in 21 of the 26 regions. The five regions that do not have any regional PPOs are: Alaska, Colorado/New Mexico, Connecticut/Massachusetts/ Vermont, Idaho/Oregon/Utah/Washington, and Maine/New Hampshire.

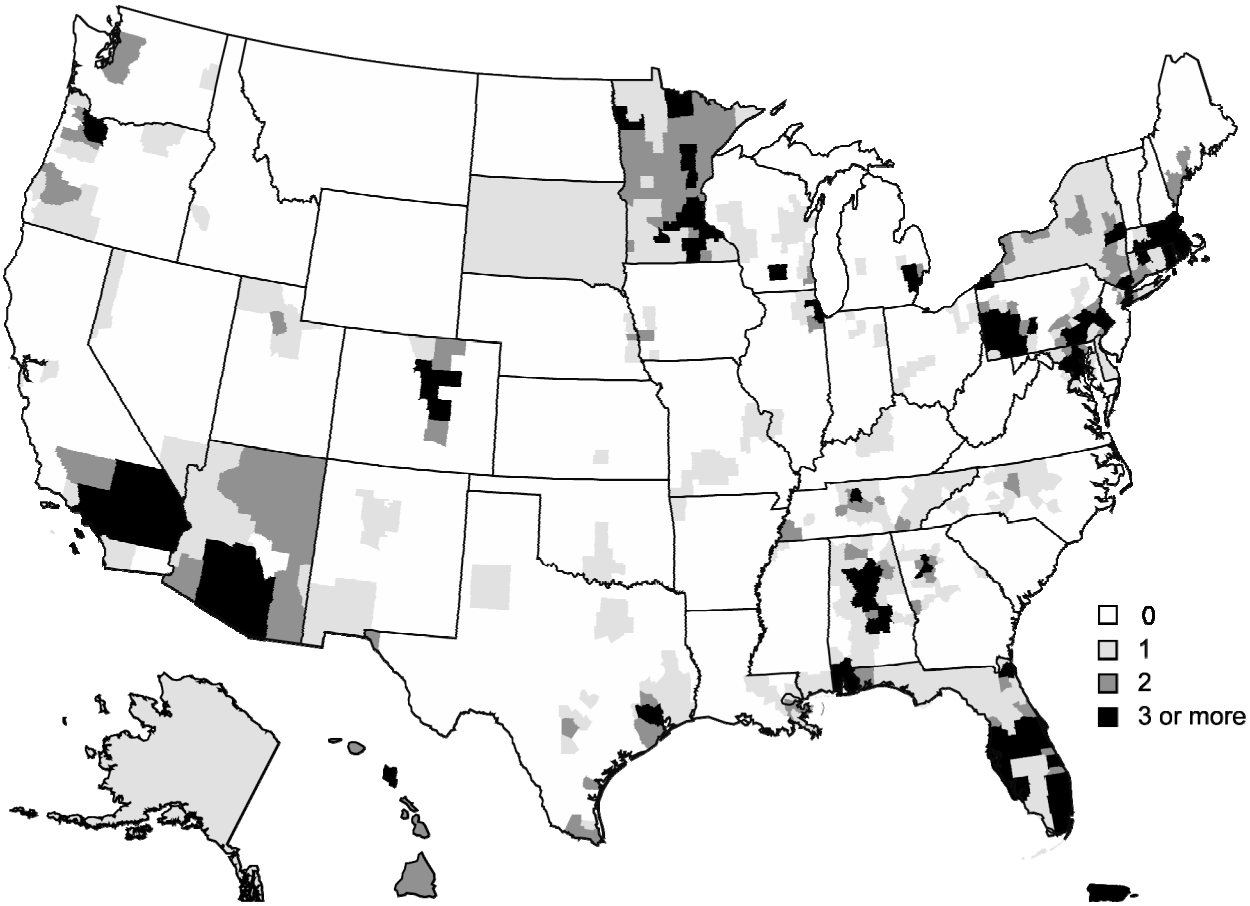
Chart 10-6. Special needs plans have grown quickly



Source: CMS special needs plan fact sheet and data summary, February 14, 2006.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the 2003 Medicare Prescription Drug, Improvement and Modernization Act to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- In 2006, 276 SNPs are approved to operate.
- Most SNPs—82 percent—are for dual eligibles, while 13 percent are for beneficiaries who reside in institutions, and 4 percent are for beneficiaries with chronic conditions.
- SNPs were authorized for only five years. Absent congressional action, SNP authority will expire at the end of 2008.

Chart 10-7. Number of organizations offering special needs plans, by county, 2006



Source: MedPAC analysis of CMS 2006 Plan Benefit Package data.

- In 2006, special needs plans (SNPs) are available in at least part of 42 states, the District of Columbia, and Puerto Rico. Fifty-nine percent of Medicare beneficiaries live in an area where a SNP is offered.
- Eight states, the District of Columbia, and Puerto Rico have at least one SNP available throughout the entire area.
- Several states have multiple types of SNPs available.
- SNPs are offered as regional preferred provider organizations in Florida, Hawaii, and New York.

Web links. Medicare Advantage

- Chapter 9 of MedPAC's June 2006 Report to the Congress provides information on Medicare Advantage plans.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch09.pdf

- Chapter 3 of MedPAC's June 2005 Report to the Congress provides information on Medicare Advantage plans.

  http://www.medpac.gov/publications/congressional_reports/June05_Ch3.pdf

- More information on the Medicare Advantage program payment system can be found in MedPAC's Medicare Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_MA.pdf

- CMS provides information on Medicare+Choice and other Medicare managed care plans.

  http://cms.hhs.gov/healthplans/

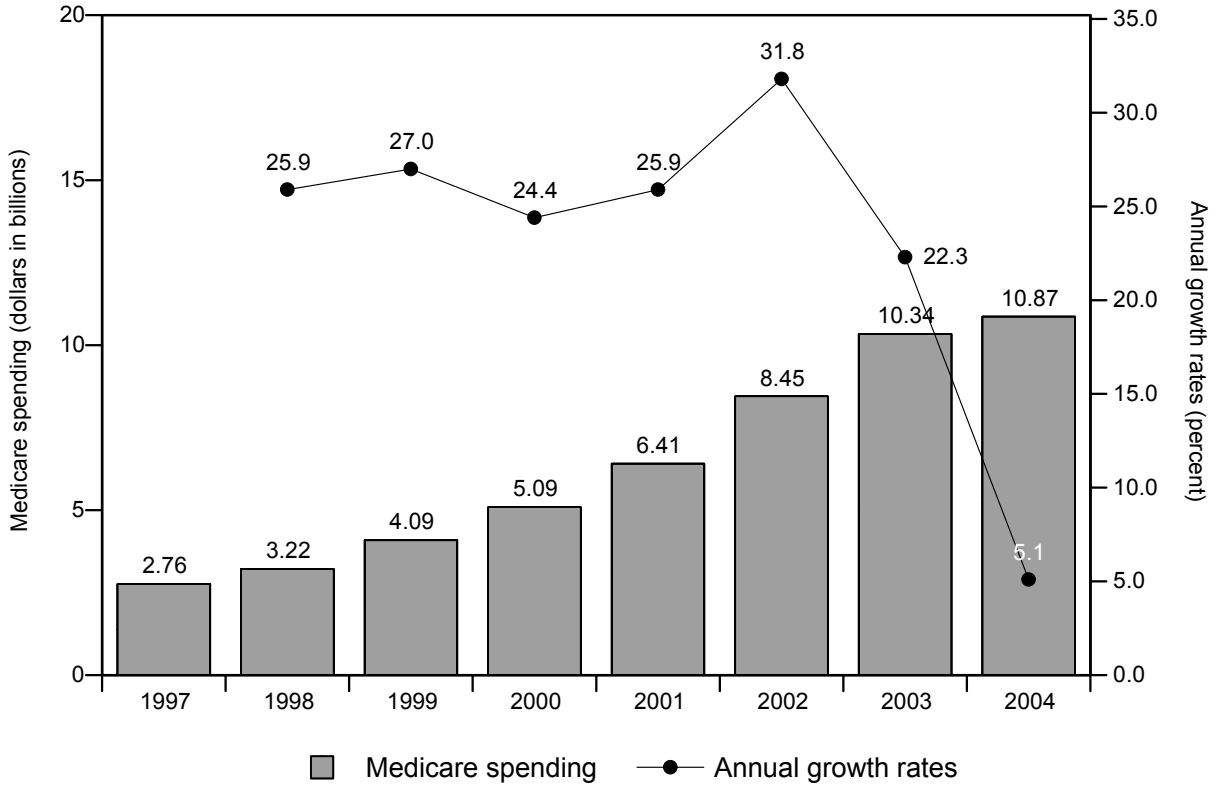
- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

  http://www.medicare.gov/mphCompare/home.asp

SECTION 11

Drugs

Chart 11-1. Medicare spending and annual growth rates for Part B drugs



Source: MedPAC analysis of unpublished CMS data.

- MedPAC estimates that spending for Part B drugs totaled $10.9 billion in 2004, an increase of 5.1 percent over 2003. This sum represents about 4 percent of total Medicare spending.

- These totals do not include drugs provided through outpatient departments of hospitals or for end-stage renal disease patients in dialysis facilities. MedPAC estimates that in 2004, freestanding and hospital-based dialysis facilities alone billed Medicare an additional $3.2 billion for drugs.

- The primary reason for growth in these expenditures is the increased volume of drugs used and the substitution of newer and more expensive medications for older therapies.

- In 2005, CMS changed its reimbursement rate to 106 percent of the average sales price (ASP). Preliminary estimates by CMS indicate that spending for Part B drugs in 2005 declined by 3 percent.

Chart 11-2. Top 10 drugs covered by Medicare Part B, by share of expenditures, 2004

Drug name	Clinical indications	Competition	FDA approval date	Percent of spending
Non-ESRD erythropoietin	Anemia	Multisource biological	1989	9.0%
Darbepoetin alfa	Anemia	Sole source	2001	7.9
Rituximab	Non-Hodgkins lymphoma	Sole source biological	1997	5.5
Ipratropium bromide	Asthma	Generic	1993	5.4
Leuprolide acetate suspension	Prostate cancer	Multisource	1985	5.3
Infliximab	Rheumatoid arthritis, Crohn's disease	Sole source biological	1999	5.0
Pegfilgrastim	Cancer	Sole source	2002	4.6
Albuterol	Asthma	Generic	1982	3.7
Goserelin acetate implant	Prostate cancer	Sole source	1989	3.4
Unclassified new drugs	Various	N/A	4/1/03 to present	3.0

Note: ESRD (end-stage renal disease), FDA (Food and Drug Administration), N/A (not available).
*Drugs that the FDA has approved since April 1, 2003 are categorized as unclassified new drugs.

Source: MedPAC analysis of 2004 Medicare claims data from CMS and unpublished FDA data.

- Medicare covers about 550 outpatient drugs, but spending is very concentrated. The top 10 drugs account for about 53 percent of all Part B spending.
- Spending for new drugs dominates the list. Of the top 10 drugs covered by Medicare in 2003, four received Food and Drug Administration approval in 1996 or later. In addition, spending on injectables too new to have received their own payment codes accounted for 3 percent of Part B drug spending.
- Treatment for cancer dominates the list—16 of the top 20 drugs treat cancer or the side effects associated with chemotherapy.

Chart 11-3. Part D enrollment and other sources of drug coverage in early 2006

	Millions enrolled as of					
	1/13/2006	2/11/2006	3/13/2006	4/18/2006	5/7/2006	6/11/2006
Enrollment that leads to Medicare program spending:						
Voluntary enrollees in stand-alone PDPs	3.6	4.9	6.4	8.1	8.9	10.4
Enrollees in MA–PDs (including some duals)	5.1	5.3	5.7	5.8	5.9	6.0
Individuals dually eligible for Medicare and Medicaid and auto-enrolled in Part D plans	5.6	5.7	5.8	5.8	5.9	6.1
Individuals covered by Medicare RDS	6.4	6.4	6.2	6.8	6.9	6.9
Subtotal	20.6	22.3	24.0	26.5	27.6	29.4
Enrollment that does not lead to Medicare program spending*:						
Estimated federal retirees in FEHB and Tricare	3.1	3.1	3.5	3.5	3.5	3.5
Total	23.8	25.4	27.6	30.0	31.1	32.8

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program). Tricare is the health program for military retirees and their dependents. For calendar year 2006, CMS projects that an average of 43.1 million beneficiaries will be enrolled in Medicare Parts A and/or B. Columns may not sum due to rounding.
*In addition, CMS estimates that 5.4 million Medicare beneficiaries have drug coverage of equal or greater value to Part D benefits through the Department of Veterans Affairs, Indian Health Service, former employers that do not receive Medicare's retiree drug subsidy, current employers, or state pharmaceutical assistance programs.

Source: CMS press releases dated as shown above.

- As of June 2006, CMS estimated that 29.4 million of the 43 million Medicare beneficiaries (68 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored coverage under Medicare's retiree drug subsidy (RDS). (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal or greater in value to Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)
- Voluntary enrollees in stand-alone drug plans numbered 10.4 million, or 24 percent of all Medicare beneficiaries. Individuals who are dually eligible for Medicare and Medicaid and enrollees in Medicare Advantage–Prescription Drug plans numbered 6.0 million and 6.1 million, respectively; each group is 14 percent of all beneficiaries. Individuals whose employers received Medicare's RDS numbered 6.9 million, or 16 percent. Those four groups of beneficiaries directly affect Medicare program spending.
- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 3.5 million beneficiaries (8 percent) were federal retirees who receive drug coverage through the Federal Employees Health Benefits program or Tricare. Another 5.4 million others (12 percent) (not shown) had prescription drug coverage through the Department of Veterans Affairs, Indian Health Service, other former employers that are not a part of Medicare's RDS, current employers because the individual is still an active worker, or state pharmaceutical assistance programs.

Chart 11-4. Characteristics of Medicare PDPs in 2006

	All types of benefits	Basic benefits: Defined standard	Basic benefits: Actuarially equivalent	Enhanced benefits
Total number of plans	1,429	132	689	608
Distribution of plans				
Plan type	100%	9%	48%	43%
Type of deductible				
Zero	58	N/A	18	40
Reduced	8	N/A	5	3
$250	34	9	25	0
Cost-sharing structure before the initial coverage limit				
Uses 25% coinsurance	9	9	0	0
Uses tiered cost sharing	91	N/A	48	43
Copays	21	N/A	8	13
Coinsurance	3	N/A	2	0
Combination	67	N/A	38	30
Coverage in the gap				
Generics	13	N/A	0	13
Generics and brands	2	N/A	0	2
None	85	N/A	48	27
Offers mail-order pharmacy services	91	8	43	40

Note: PDP (prescription drug plan), N/A (not applicable). Percentages are not weighted by plan enrollment. The PDPs described here exclude those offered in U.S. territories. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

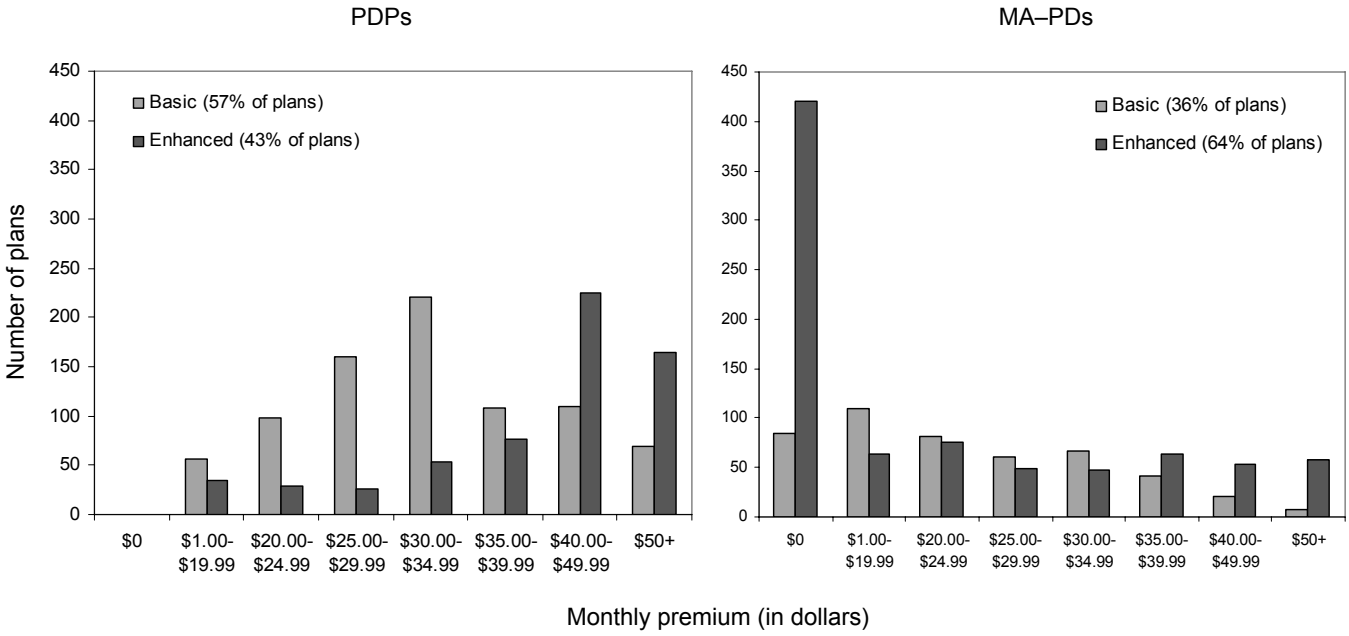
- Among all 1,429 prescription drug plans (PDPs), 57 percent provide basic benefits—either Part D's standard benefit design (9 percent) or a benefit that is actuarially equivalent to the standard benefit (48 percent). The remaining plans are enhanced (43 percent); they include basic benefits and some supplemental coverage.

- Fifty-eight percent of the 1,429 PDPs do not charge a deductible, 34 percent use the standard benefit's $250 deductible, and the remaining 8 percent use deductibles that are less than $250. No enhanced plans use the standard benefit's $250 deductible, and many actuarially equivalent plans charge no deductible either. A plan could charge no deductible yet maintain actuarial equivalence to the standard benefit by charging higher cost sharing or lowering the benefit's initial coverage limit.

- Most plans (91 percent) use cost-sharing tiers rather than the defined standard benefit's flat 25 percent coinsurance. However, 67 percent of all PDPs use a combination of copays for some (usually lower price) tiers and coinsurance (typically for specialty drugs placed on higher price tiers).

- Relatively few PDPs offer any coverage in the standard benefit's coverage gap.

Chart 11-5. Distribution of PDP and MA–PD premiums for basic and enhanced plans in 2006



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Distributions are not weighted by beneficiary enrollment. Total number of PDPs is 1,429, which excludes plans offered in U.S. territories. Total number of MA–PDs is 1,303, which excludes demonstration programs, 1876 cost plans, and plans offered in U.S. territories. MA–PD enrollees must pay any other Medicare Advantage premiums in order to obtain Part D prescription drug coverage. Benefits labeled basic include Part D's standard benefit design as well as benefits that are actuarially equivalent to standard benefits. Enhanced plans include supplemental coverage.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Among all basic prescription drug plans (PDPs) (defined standard benefits and those that are actuarially equivalent), the simple average monthly premium is $33. CMS officials have noted that beneficiary premiums are expected to average $23 per month. The reason for this difference is that the $23 figure is weighted by Part D enrollment.

- At the median, premiums for enhanced PDPs run about $10 more per month than premiums for basic PDPs. Within each category of basic and enhanced plans, there is quite a bit of variation among premiums. Some enhanced benefits cost less than $20 per month in certain regions, while other basic plans cost more than $50 per month.

- Medicare Advantage–Prescription Drug plans (MA–PDs) tend to have lower premiums for their drug benefits than PDPs. More than 500 MA–PDs (nearly 40 percent) charge no additional premium for Part D coverage beyond what the plan charges for Parts A and B services.

Chart 11-6. PDPs offered in 2006 by organizations with at least one nationwide plan

Organization	Plan name	Regions in which plan is offered	Plans qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
Aetna	**Aetna Medicare Rx Essentials**	**34**	**6**	**Actuarially equivalent**	**$28–$39**	**$250**	**$5/$25**	None
	Aetna Medicare Rx Plus	**34**	**0**	**Enhanced**	**37–50**	**0**	**$7/$35**	Generics
	Aetna Medicare Rx Premier	**34**	**0**	**Enhanced**	**52–67**	**0**	**$2/$20/$40**	Generics
Cigna	CIGNATURE Rx Value Plan	34	7	Actuarially equivalent	30–37	250	$4/$20/$40	None
	CIGNATURE Rx Plus Plan	34	0	Enhanced	40–42	0	$5/$30/$50	None
	CIGNATURE Rx Complete Plan	34	0	Enhanced	43–51	0	$5/$30/$50	Generics
Coventry	**AdvantraRx Value**	**34**	**0**	**Enhanced**	**18–25**	**0**	**$10–$15/$36–$60**	None
	AdvantraRx Premier	**34**	**0**	**Enhanced**	**29–38**	**0**	**$5–$10/$20–$40/ $50–$70**	None
	AdvantraRx Premier Plus	**34**	**0**	**Actuarially equivalent**	**40–50**	**0**	**$5/$20–$40/$54–$70**	None
Medco	YOURx Plan	34	19	Actuarially equivalent	27–36	250	$4/$17/75%/25%	None
MemberHealth	**Community Care Rx Basic**	**34**	**23**	**Actuarially equivalent**	**26–33**	**250**	**0%/25%/45%**	None
	Community Care Rx Choice	**34**	**0**	**Actuarially equivalent**	**34–41**	**250**	**$4/$20/$40**	None
	Community Care Rx Gold	**34**	**0**	**Enhanced**	**38–45**	**100**	**$4/$25/$50**	None
PacifiCare	PacifiCare Saver	34	31	Actuarially equivalent	19–35	0	$8/$22/$47–$53/33%	None
	PacifiCare Select	34	2	Actuarially equivalent	30–49	0	$8/$22/$56–$73/33%	None
	PacifiCare Comprehensive Plan	2	0	Enhanced	37–41	0	$8/$22/$53–$54/33%	Generics
	PacifiCare Complete Plan	32	0	Enhanced	34–55	0	$8/$22/$22–$54/ $53/33%/33%	Generics

Organization	Plan name	Regions in which plan is offered	Plans qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
Silverscript	**SilverScript**	**34**	**27**	**Actuarially equivalent**	**$24–33**	**$250**	**$7–$9/25%/25%**	**None**
	SilverScript Plus	**34**	**0**	**Actuarially equivalent**	**49–63**	**100**	**$7–$8/$22–$25/ $60–$62/25%**	**None**
Unicare	Medicare Rx Rewards	34	34	Actuarially equivalent	17–31	250	$5/$25/25%/25%	None
	Medicare Rx Rewards Plus	33	0	Enhanced	26–39	0	$10/$30/25%/25%	None
	Medicare Rx Rewards Premier	33	0	Enhanced	35–52	0	$10/$30/$60/30%/ 30%	Generics
United	**AARP Medicare Rx**	**34**	**33**	**Actuarially equivalent**	**23–30**	**0**	**$5/$28/$55–$56/25%**	**None**
	United Health Rx	**4**	**4**	**Actuarially equivalent**	**21–23**	**50**	**$7/$23/$54/25%**	**None**
	United Medicare MedAdvance	**34**	**28**	**Actuarially equivalent**	**27–32**	**0**	**$10/$23/$52–$55/ 25%**	**None**
WellCare	WellCare Signature	34	33	Actuarially equivalent	17–33	0	$0/$0/$62–$73/ $62–$73/30%–33%	None
	WellCare Complete	34	0	Enhanced	33–51	0	$0/$0/$15/$50/30%	None
	WellCare Premier	34	0	Enhanced	35–54	0	$0/$0/$30/$60/30%	None

Note: PDP (prescription drug plan). Benefits labeled as actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The PDPs described here exclude those offered in U.S. territories.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Ten organizations have at least one plan in all 34 of the prescription drug plan (PDP) regions across the nation (excluding U.S. territories). The offerings of these 10 organizations account for nearly 900 of the 1,429 PDPs available across the 34 regions.

- None of these organizations offers Part D's defined standard benefit design for 2006. Instead, most use tiered copays or a combination of copays and coinsurance, and keep the standard benefit's $2,250 initial coverage limit. Many of the plans have equivalent actuarial values to the standard benefit, but charge no deductible or a deductible lower than the standard benefit's $250. While most of these sponsoring organizations chose to offer one or more enhanced plans, fewer than half of those enhanced plans provide coverage in the standard benefit's coverage gap.

Chart 11-7. "Near-national" organizations with 30 or more PDPs among the 34 regions

Organization	Plan name	Regions in which plan is offered	Number qualifying for auto-enrollment	Type of benefit	Range of monthly premiums	Deductible	Cost sharing by tier at in-network preferred pharmacies	Gap coverage
American Progressive	Prescription Pathway Bronze	1	1	Defined standard	$25	$250	25%	None
	Prescription Pathway Silver	8	0	Actuarially equivalent	34–41	250	$5–$6/$27–$28/25%	None
	Prescription Pathway Gold	8	0	Enhanced	46–52	0	$5–$6/$27–$28/25%	None
	Prescription Pathway Platinum	7	0	Enhanced	64–69	0	$6/$24/$40/25%	None
Marquette	Prescription Pathway Silver	22	0	Actuarially equivalent	34–43	250	$4/$29/25%	None
	Prescription Pathway Gold	22	0	Enhanced	46–54	0	$4/$29/25%	None
	Prescription Pathway Platinum	22	0	Enhanced	62–71	0	$4/$26/$42/25%	None
Pennsylvania Life	Prescription Pathway Bronze	31	25	Defined standard	24–34	250	25%	None
	Prescription Pathway Silver	31	0	Actuarially equivalent	34–43	250	$5/$28/25%	None
	Prescription Pathway Gold	31	0	Enhanced	46–54	0	$5/$28/25%	None
Humana	Humana PDP Standard	31	30	Defined standard	2–18	250	25%	None
	Humana PDP Enhanced	31	0	Enhanced	5–25	0	$7/$30/$60/25%	None
	Humana PDP Complete	31	0	Enhanced	39–73	0	$7/$30/$60/25%	Generics, brands
Sterling	Sterling Prescription Drug Plan	32	0	Actuarially equivalent	49–61	100	$10/$22–$28/ 40%–50%/25%	None
United American	UA Medicare Part D Prescription Drug Coverage	31	2	Actuarially equivalent	30–41	0	$9/$30/$60/33%	None

Note: PDP (prescription drug plan). Benefits labeled as actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region. Plans with "gap coverage" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The PDPs described here exclude those offered in U.S. territories.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- While they are not national plans, another 6 organizations are major participants in Part D—they offer 30 or more prescription drug plans (PDPs) across the 34 regions. A few of these organizations offer a larger total number of plans than do some of the 10 organizations with nationwide offerings. Combined, these "near-national" entities contribute more than 300 of the 1,429 PDPs available across the 34 regions.
- For 2006, several of these organizations offer Part D's defined standard benefit.

Chart 11-8. Premiums and cost-sharing requirements among PDPs in 2006

	Basic benefits		
	Defined Standard*	Actuarially equivalent	Enhanced benefits
Monthly premium			
Minimum	$2	$14	$5
Maximum	85	63	105
Median	28	32	44
Mean	26	35	43
Deductible			
Minimum	250	0	0
Maximum	250	250	150
Median	250	250	0
Median cost sharing for:			
Plans with generic/brand tier structure			
Generic copay	N/A	5	7
Brand copay	N/A	28	30
Specialty tier coinsurance (where applicable)	N/A	25%	25%
Plans with generic/preferred brand/nonpreferred brand tier structure			
Generic copay	N/A	$7	$5
Preferred brand copay	N/A	22	26
Nonpreferred brand copay	N/A	55	50
Specialty tier coinsurance (where applicable)	N/A	25%	30%

Note: PDP (prescription drug plan), N/A (not applicable). Values do not reflect plan enrollment. The PDPs described here exclude plans offered in U.S. territories. Cost sharing is for median cost sharing among plans that use tiered cost sharing before the initial coverage limit. Benefits labeled actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits.
*The defined standard benefit charges 25 percent coinsurance between a $250 deductible (in 2006) and the benefit's initial coverage limit of $2,250 in covered drug spending (in 2006).

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Across all types of prescription drug plan (PDP) benefits offered among the 1,429 plans (including both basic and enhanced packages), the lowest-premium plan is a defined standard benefit at a cost of just under $2 per month, while the higher premium plan provides enhanced coverage for about $105 per month.

- Plans that use tiered cost sharing tend to charge fixed-dollar copays rather than a percentage coinsurance of the prescription's price. Among plans that use a generic/brand tier structure, median copays for generic drugs are $5 to $7, and those for brand name drugs are $28 to $30. Plans that distinguish between preferred and nonpreferred brand name drugs charge copays of $7 to $5 for generics, $22 to $26 for preferred brand name drugs, and $55 to $50 for nonpreferred brand name drugs. Many plans use a separate tier for higher cost specialty drugs, such as biologics. PDPs that use a specialty tier tend to charge 25 percent to 30 percent coinsurance. Based on CMS guidance, plan enrollees may not appeal payment of a lower tier's cost-sharing requirement for such specialty drugs.

Chart 11-9. Geographic distribution of PDPs in 2006

PDP region	States in the region	Number of PDPs: Total	Number of PDPs: That qualify for auto-enrollment	Number of PDPs: With a monthly premium ≤ $20	Mean premium for: Basic benefits	Mean premium for: Enhanced benefits
1	ME, NH	41	14	1	$35	$44
2	CT, MA, RI, VT	44	11	4	31	42
3	NY	46	15	6	32	37
4	NJ	44	14	4	32	41
5	DC, DE, MD	47	15	3	33	45
6	PA, WV	52	15	2	34	45
7	VA	41	16	2	34	44
8	NC	38	13	2	37	46
9	SC	45	16	1	35	47
10	GA	42	14	1	34	43
11	FL	43	6	4	34	47
12	AL, TN	41	9	1	35	48
13	MI	40	14	1	34	43
14	OH	43	10	3	33	42
15	IN, KY	42	13	1	36	46
16	WI	45	14	4	31	41
17	IL	42	15	1	32	43
18	MO	41	10	2	34	43
19	AR	40	13	2	35	46
20	MS	38	12	2	36	47
21	LA	39	11	1	38	48
22	TX	47	16	2	33	44
23	OK	42	12	2	36	46
24	KS	40	11	2	34	42
25	IA, MN, MT, ND, NE, SD, WY	41	14	3	32	44
26	NM	43	8	6	29	41
27	CO	43	10	3	32	41
28	AZ	43	6	4	31	40
29	NV	44	7	3	30	40
30	OR, WA	45	15	5	31	41
31	ID, UT	44	14	3	34	44
32	CA	47	10	6	28	38
33	HI	29	8	3	31	37
34	AK	27	8	0	34	41
Total		1,429	409	90	33	43

Note: PDP (prescription drug plan). Mean values are not weighted by plan enrollment. The PDPs described here exclude plans offered in U.S. territories. Benefits labeled basic include Part D's standard benefit design as well as benefits that are actuarially equivalent to standard benefits. Enhanced plans include supplemental coverage. Plans that "qualify for auto-enrollment" have premiums that are at or below threshold values calculated by CMS for each PDP region.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- For 2006, all regions of the country experienced strong plan entry among stand-alone PDPs. Every region has at least 27 PDPs offering Part D coverage and the median number of plans per region is 43. Medicare beneficiaries who qualify to receive Part D's low-income subsidies have a broad choice of PDPs available. All regions but Alaska have at least one PDP available with a monthly premium of $20 or less.

Chart 11-10. Characteristics of MA–PDs' drug benefits in 2006

	All types of benefits	Basic benefits		Enhanced benefits
		Defined standard	Actuarially equivalent	
Total number of plans	1,303	96	376	831
Distribution of plans (in percent):				
Plan type	100%	7%	29%	64%
Type of organization				
Local HMO	66	4	18	43
Local PPO	21	1	8	12
PFFS	10	1	2	7
Regional PPO	4	1	1	2
Type of deductible				
Zero	80	N/A	18	62
Reduced	3	N/A	2	1
$250	17	7	8	1
Cost-sharing structure before the initial coverage limit				
Uses 25% coinsurance	7	7	0	0
Uses tiered cost sharing	93	N/A	29	64
Copays	34	N/A	16	17
Coinsurance	0	N/A	0	0
Both	59	N/A	13	46
Coverage in the gap				
Generics	23	N/A	0	23
Generics and branded	5	N/A	0	5
None	72	N/A	29	36
Offers mail-order pharmacy services	96	7	27	62

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee for service), N/A (not applicable). Local plans (HMOs, PPOs, and PFFS plans) select individual counties in which they operate. Regional PPOs must provide Medicare services throughout a CMS-defined region that encompasses one or more states. Percentages are not weighted by plan enrollment. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits. Plans with "coverage in the gap" include some benefits in the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- In addition to stand-alone PDPs, private health plans are offering 1,303 MA–PDs around the country. In order to enroll in an MA–PD, beneficiaries must elect to have their health care services (e.g., hospital and physician care) provided by the MA–PD. The vast majority of MA–PDs are offered at a local level; that is, availability varies depending on the county in which a beneficiary lives.

- The law allows MA–PDs to use 75 percent of the difference between an MA plan's benchmark payment and its bid for providing Parts A and B services (called rebate dollars) to supplement its package of benefits or lower its premium, including Part D premiums. For this reason, offerings through MA–PDs differ systematically from PDPs.

- A much larger proportion of MA–PDs (64 percent) provide enhanced benefits than do PDPs (43 percent). For 2006, 80 percent of all MA–PDs have no deductible compared with 58 percent of PDPs. They are also more likely to provide coverage within Part D's coverage gap: 23 percent of MA–PDs offer coverage of generic drugs, and another 5 percent of MA–PDs provide coverage of both generic and brand-name drugs. By comparison, 13 percent of PDPs offered generic coverage in the gap and 2 percent covered generic and brand name drugs.

Chart 11-11. Premiums and cost-sharing requirements among MA–PD drug benefits in 2006

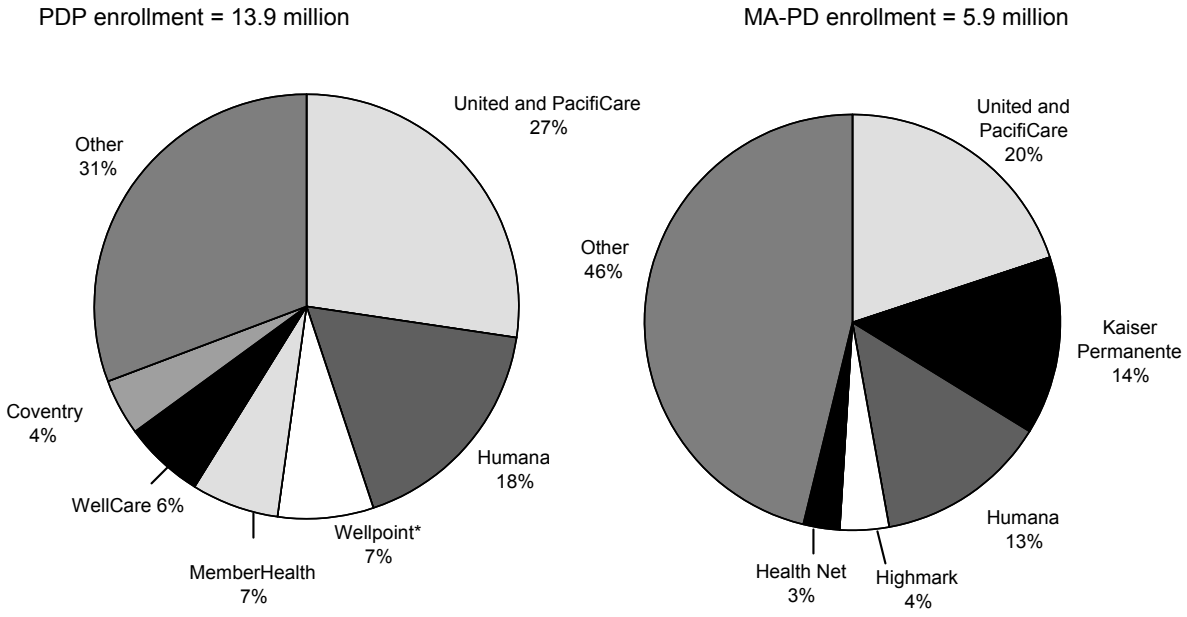
	Basic benefits		
	Defined Standard*	Actuarially equivalent	Enhanced benefits
Monthly drug premium			
Minimum	$0	$0	$0
Maximum	77	78	120
Median	23	24	0
Mean	25	21	16
Monthly total plan premium (including medical and drug premiums)			
Minimum	0	0	0
Maximum	202	179	260
Median	63	63	29
Mean	68	61	41
Deductible			
Minimum	250	0	0
Maximum	250	250	250
Median	250	0	0
Median cost sharing for:			
Plans with generic/brand tier structure			
Generic copay	N/A	5	7
Brand copay	N/A	30	30
Specialty tier coinsurance (where applicable)	N/A	25%	30%
Plans with generic/preferred brand/nonpreferred brand tier structure			
Generic copay	N/A	$5	$5
Preferred brand copay	N/A	29	28
Nonpreferred brand copay	N/A	55	50
Specialty tier coinsurance (where applicable)	N/A	25%	25%

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), N/A (not applicable). Values are not weighted by plan enrollment. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Cost sharing is for median cost sharing among plans that use tiered cost sharing before the initial coverage limit. Benefits labeled actuarially equivalent to Part D's standard benefit include actuarially equivalent standard and basic alternative benefits. *Part D's defined standard benefit has a $250 deductible (in 2006) and 25 percent coinsurance below an initial coverage limit of $2,250 (in 2006).

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- Many Medicare Advantage organizations have applied some of their rebate dollars toward the premiums of enhanced plans. In 2006, the median monthly premium for an enhanced Medicare Advantage–Prescription Drug plan (MA–PD) is essentially zero. However, not every beneficiary has access to a zero-premium enhanced plan; availability depends on the county in which they live.
- In order to obtain MA–PD coverage, enrollees must pay the Part B premium and any other premium amount charged by their plan for regular medical services. The median combined MA–PD premiums for medical services and prescription drugs range from $29 to $63 per month.
- Median cost-sharing amounts are similar to those used by prescription drug plans. MA–PDs that use a generic/brand tier structure typically charge $5 to $7 to fill a generic prescription and $30 for brand name prescriptions. Plans that distinguish between preferred and nonpreferred brand name drugs have the following median copays: $5 for generics, $29 to $28 for preferred brand name drugs, and $55 to $50 for nonpreferred brand name drugs. Plans often charge 25 percent coinsurance for specialty and higher priced drugs.

Chart 11-12. Distribution of Part D enrollees by organization



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Data are as of April 27, 2006.
*Includes Blue Cross and Blue Shield New England Alliance, Blue Medicare Rx, and Unicare.

Source: MedPAC based on CMS enrollment data.

- As of late April 2006, Part D enrollment was concentrated among plans offered by a small number of parent organizations. Several of those organizations offer both stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug plans (MA–PDs). For example, United and PacifiCare (which merged recently) had 27 percent of the 13.9 million enrollees in PDPs and 20 percent of the 5.9 million enrollees in MA–PDs. Similarly, Humana had a considerable portion of both markets: 18 percent of PDP enrollees and 13 percent of MA–PD enrollees.

- As information on enrollment in specific Part D plans becomes available, the Commission will monitor those data to see how they affect plans' decisions to enter or exit the market.

Chart 11-13. Most Part D plans distinguish between preferred and nonpreferred brands and include specialty tiers

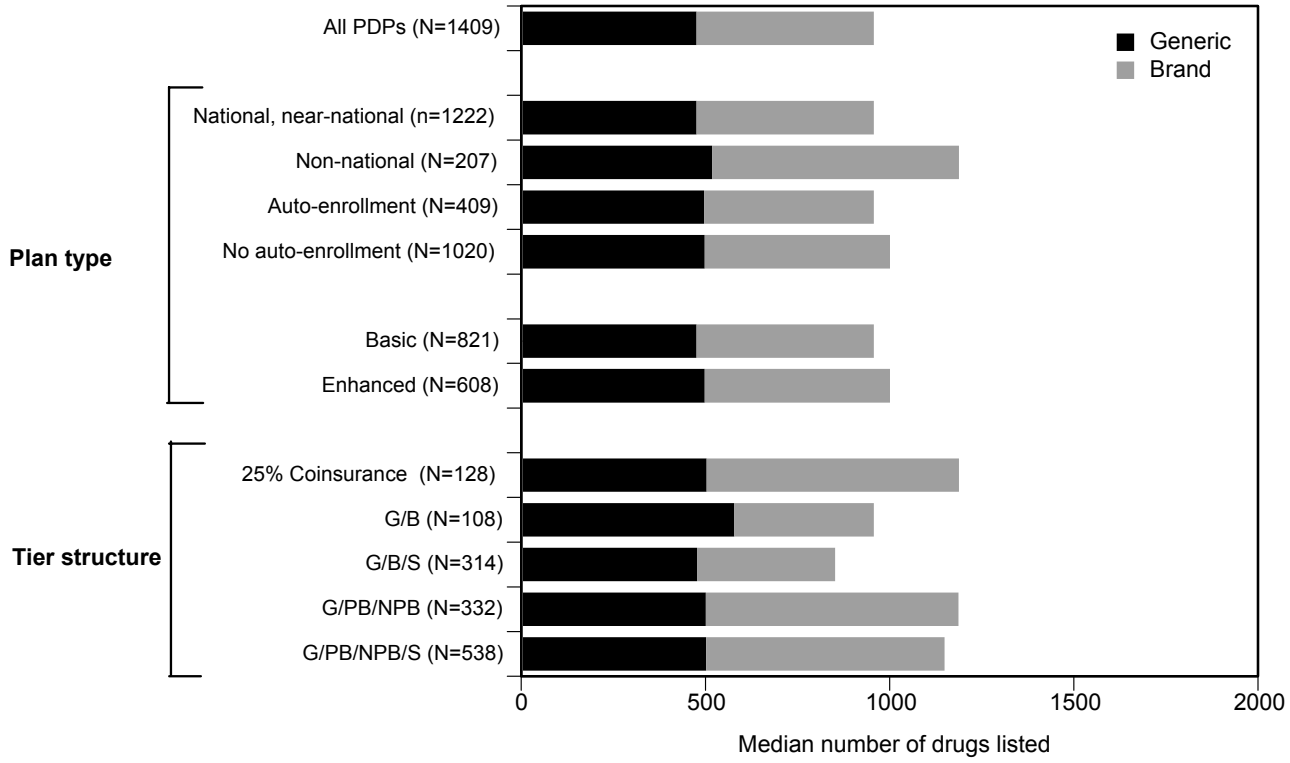
Plan characteristics	Distribution of plans by tier structures					
		Generic/brand		Generic/preferred brand/ nonpreferred brand		
	25% coinsurance, all tiers	Without specialty tier	With specialty tier	Without specialty tier	With specialty tier	Other
All Part D plans	8%	11%	15%	19%	45%	2%
All PDPs	9	8	22	23	38	1
National, near-national	5	8	21	25	40	0
Non-national	31	3	28	12	21	4
Auto-enrollment	23	2	33	9	33	1
No auto-enrollment	3	10	18	29	40	0
Basic	16	5	25	18	36	1
Enhanced	0	12	18	30	40	0
All MA–PDs	7	16	6	15	53	3
Local HMO	6	15	5	14	58	2
Local PPO	6	21	8	24	37	5
Regional PPO	29	8	15	10	38	0
PFFS	10	11	11	0	67	0
Basic	18	21	10	16	32	2
Enhanced	1	13	5	14	65	3

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service). The PDPs described here exclude plans offered in U.S. territories. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Auto-enrollment refers to PDPs that were eligible for automatically enrolled beneficiaries based on low-income status. Cost-sharing structures are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals, such as biotechnology drugs, for which enrollees may not appeal for lower cost-sharing amounts. Numbers may not sum to 100 percent due to rounding.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Most Part D formularies distinguish between preferred and nonpreferred brands. About a quarter of Part D plans distinguish only between brand name and generic drugs. Less than 10 percent of plans have 25 percent cost sharing for all covered drugs.
- 61 percent of PDPs and 68 percent of MA–PDs use the generic, preferred, and nonpreferred brand structure.
- PDPs with flat, 25 percent cost sharing were more likely to be non-national, basic, and qualify for auto-enrollment. Enhanced plans almost never use this structure.
- 60 percent of plans include a specialty tier in their formulary designs for expensive products and unique drugs and biologicals. Beneficiaries may not appeal the cost-sharing amount (generally limited to 25 percent) for drugs listed on a specialty tier.

Chart 11-14. Part D plans typically list about 1,000 drugs: PDPs

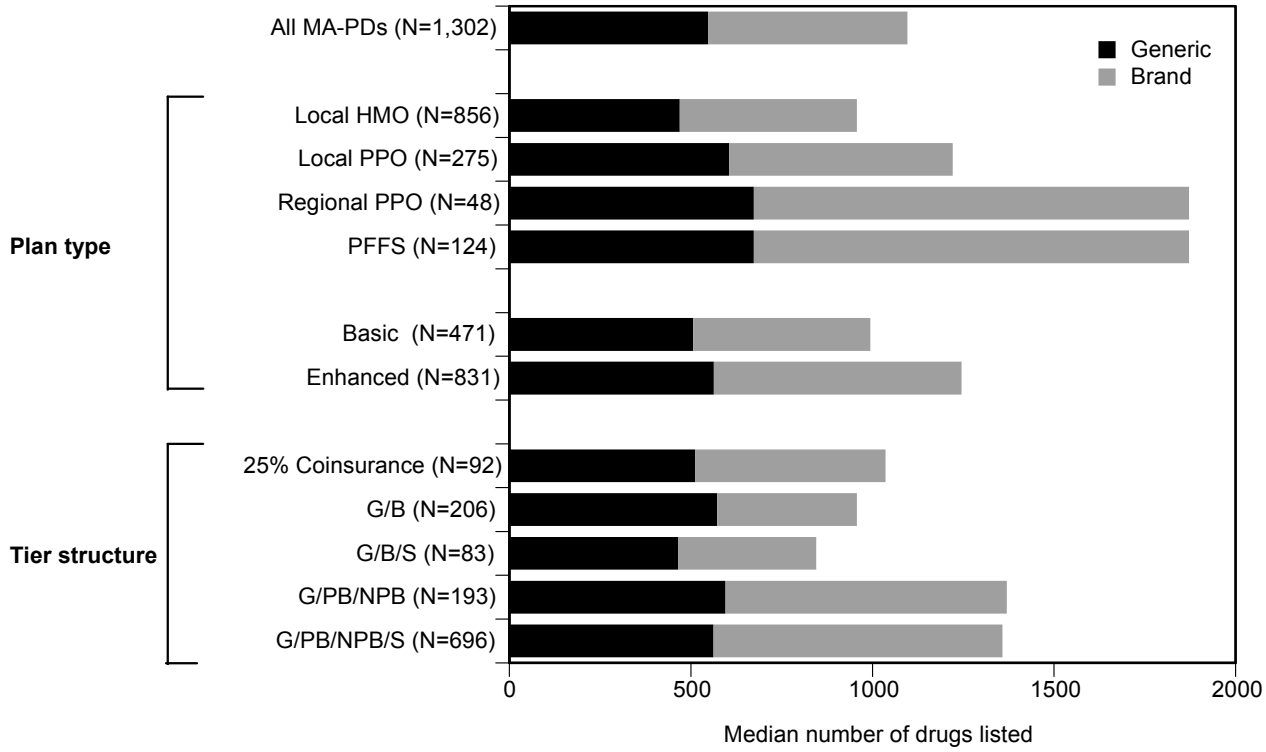


Note: PDP (prescription drug plan), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with "other" tier structures are not displayed. The PDPs described here exclude plans offered in U.S. territories. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Plan formularies in Part D typically list about 1,000 drugs. Among prescription drug plans (PDPs), the total number of drugs listed ranges from 618 drugs to 1,743 with a median of 957 drugs.
- Among PDPs, the non-national plans carry the largest formularies. Plans that are eligible for auto-enrollees typically list almost the same number of total drugs (and brand name drugs) as plans without auto-enrollment.
- Plans with only one brand-name tier typically list fewer drugs than plans with preferred and nonpreferred brand tiers on their formularies.
- The number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan's nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-15. Part D plans typically list about 1,000 drugs: MA–PDs



Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with "other" tier structures are not displayed. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Cost-sharing are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Plan formularies in Part D typically list about 1,000 drugs. Among Medicare Advantage–Prescription Drug plans (MA–PDs), the total number of drugs listed ranges from 509 to 2,130, with a median of 1,096.

- Among MA–PDs, regional preferred provider organizations and private fee-for-service MA–PDs have the largest formularies, but these plans only represent 6 percent of the Part D landscape.

- Plans with only one brand-name tier typically list fewer drugs than plans with preferred and nonpreferred brand tiers on their formularies.

- The number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan's nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-16. The share of drugs listed in a therapeutic category depends on category size and regulation

	Median percent of drugs listed by selected therapeutic categories			
	Cholinesterase Inhibitors	Dyslipidemics	Opioid analgesics	Atypical antipsychotics*
Total drugs in category	4	20	61	6
Plan type:				
PDPs	75%	65%	39%	100%
MA–PDs	75	75	48	100

Note: PDP (prescription drug plan); MA–PD (Medicare Advantage prescription drug [plan]). Descriptions of therapeutic categories are given in parentheses: cholinesterase inhibitors (antidementia agents); dyslipidemics (anticholesterol agents); opioid analgesics (narcotic pain relievers); atypical antipsychotics (nonphenothiazines). Occasionally, plans list some generic drugs on brand tiers and vice versa. This table excludes plans offered in U.S. territories. The MA–PDs described here also exclude demonstration programs and 1876 cost plans.
*Under CMS regulation, plans are required to list all drugs in the atypical antipsychotic category.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- In addition to regulatory coverage rules for certain therapeutic categories, the number of drugs Part D plans listed in a therapeutic class reflects the size of the class of drugs available in the marketplace.

- In classes with fewer drugs available, plans typically list a larger share of them. Conversely, when there are more drugs available in a given class, plans are able to negotiate better prices by listing only selected drugs on their formulary, particularly when there are overlapping products.

- For example, in a therapeutic class with only a small number of drugs, such as cholinesterase inhibitors (within the class of antidementia agents), plans typically list a higher share of available drugs in the market. But in classes where there are many drugs available in the market, such as opioid analgesics, plans typically list a much smaller share on their formularies.

- In classes for which CMS requires that plans cover all or substantially all drugs, plans predictably list a larger share of drugs. For example, in the class of atypical antipsychotics, both MA–PDs and PDPs typically list all of the available drugs.

Chart 11-17. Part D plans concentrate prior authorization in selected categories

Therapeutic category	Median percent of listed drugs subject to prior authorization, among plans that use it	
	PDPs	MA–PDs
All drugs	9%	9%
Atypical antipsychotics*	33	33
Dyslipidemics	13	17
Immune suppressants*	83	71
Metabolic bone disease agents	17	17
Molecular target inhibitors*	75	75
Opioid analgesics	12	9
Oral hypoglycemics	17	11
Proton pump inhibitors	50	75
Renin-angiotensins	2	4
Reuptake inhibitors*	5	5

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Descriptions of selected therapeutic categories are given in parentheses: atypical antipsychotics (antipsychotics, nonphenothiazines); dyslipidemics (anticholesterol agents); immune suppressants (rheumatoid arthritis agents); opioid analgesics (narcotic pain relievers); oral hypoglycemics (blood sugar level agents); proton pump inhibitors (stomach acid reducers); rennin-angiotensins (selected hypertension drugs); reuptake inhibitors (selected antidepressants). This table excludes plans offered in U.S. territories. The MA–PDs described here exclude demonstration programs and 1876 cost plans.
*Plans may only apply prior authorization to new-start enrollees—those not already taking a drug in these categories.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Most Part D plans apply drug utilization management tools to selected drugs. These tools include prior authorization (plans require pre-approval before coverage), step therapy (enrollees must try specified drugs before moving to other drugs), and quantity limits (plans limit the number of doses of a particular drug covered in a given time period).

- Plans use these tools for drugs that are expensive, potentially risky, subject to abuse, misuse, or experimental use, or to encourage use of lower-cost therapies.

- All prescription drug plans (PDPs) and almost all Medicare Advantage–Prescription Drug plans (MA–PDs) (98 percent) use prior authorization for at least one drug on their formularies. The median plan applies prior authorization to 9 percent of the drugs on its formulary. Step therapy is less commonly used among Part D plans and those that use it do so for a smaller proportion of drugs.

- In the class of proton pump inhibitors (PPIs), which have low-cost and over-the-counter drugs among the choices, PDPs and MA–PDs typically apply prior authorization to at least half of their listed PPIs.

- PDPs and MA–PDs that use prior authorization typically require it for most of the drugs in the immune suppressant category that includes expensive rheumatoid arthritis drugs. Plans are likely applying prior authorization restrictions in this category (and several other categories) to assist in determining whether the drugs should be covered under Part B instead of Part D.

Web links. Drugs

- Chapters 7 and 8 of the MedPAC June 2006 Report to the Congress provide information on the Medicare Part D program, as does MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch07.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_PartD.pdf

- Analysis of Medicare spending on oncology drugs can be found in MedPAC's January 2006 Report to the Congress: Effects of Medicare Payment Changes on Oncology Services.

  http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A Kaiser Family Foundation fact sheet, last updated in May 2006, provides information on the Medicare Part D benefit.

  http://www.kff.org/medicare/upload/7044-03-2.pdf

- A Kaiser Family Foundation analysis of formularies and other features of Medicare Part D plan.

  www.kff.org/medicare/upload/7489.pdf

- A Kaiser Family Foundation fact sheet on low-income assistance under the Medicare Part D benefit.

  www.kff.org/medicare/upload/7327.pdf

- A Kaiser Family Foundation fact sheet on enrollment in the Medicare Part D program.

  www.kff.org/medicare/upload/7466.pdf

- CMS information on Part D enrollment.

  www.cms.hhs.gov/prescriptiondrugcovgenin/02_Enrollmentdata.asp

SECTION 12

Other services

Dialysis
Hospice
Clinical laboratory
Outpatient therapy

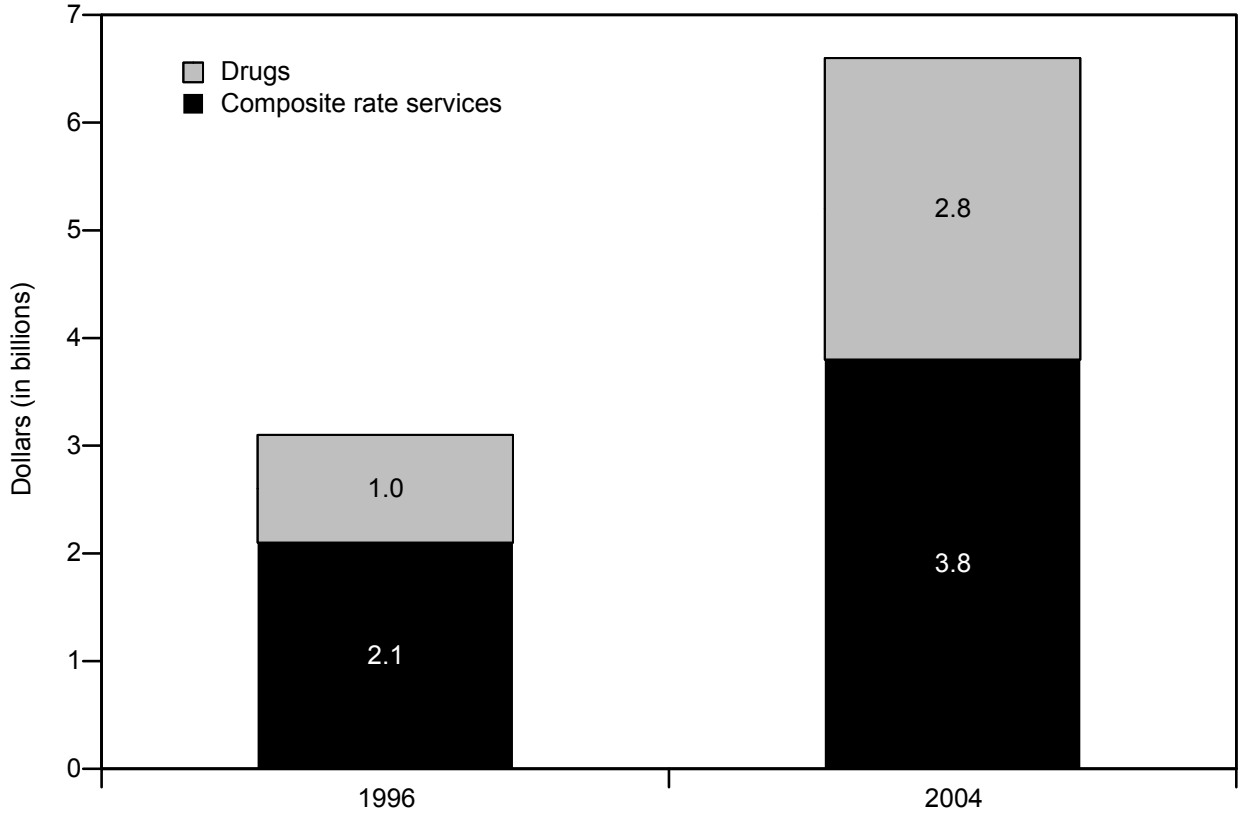
Chart 12-1. Total number of dialysis facilities is growing; for profit and freestanding are increasing over time

	1995	2000	2005
Total number of dialysis facilities	2,721	3,805	4,540
Mean number of hemodialysis stations	15	16	17
Percent of all facilities:			
Urban	76%	74%	75%
Rural	23	25	25
For profit	65	78	78
Nonprofit	35	22	22
Freestanding	74	82	86
Hospital based	26	18	14

Source: Compiled by MedPAC from the CMS facility survey file.

- Between 1995 and 2005, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 74 percent to 86 percent of all facilities, and for-profit facilities increased from 65 percent to 78 percent of all facilities.
- Two national for-profit chains own about 60 percent of all facilities and 70 percent of all freestanding facilities.
- Between 1995 and 2005, the proportion of facilities located in rural areas has remained relatively constant.
- While the number of facilities has increased 67 percent since 1995, the mean number of hemodialysis stations per facility has grown more slowly, climbing from 15 in 1995 to 17 in 2005.

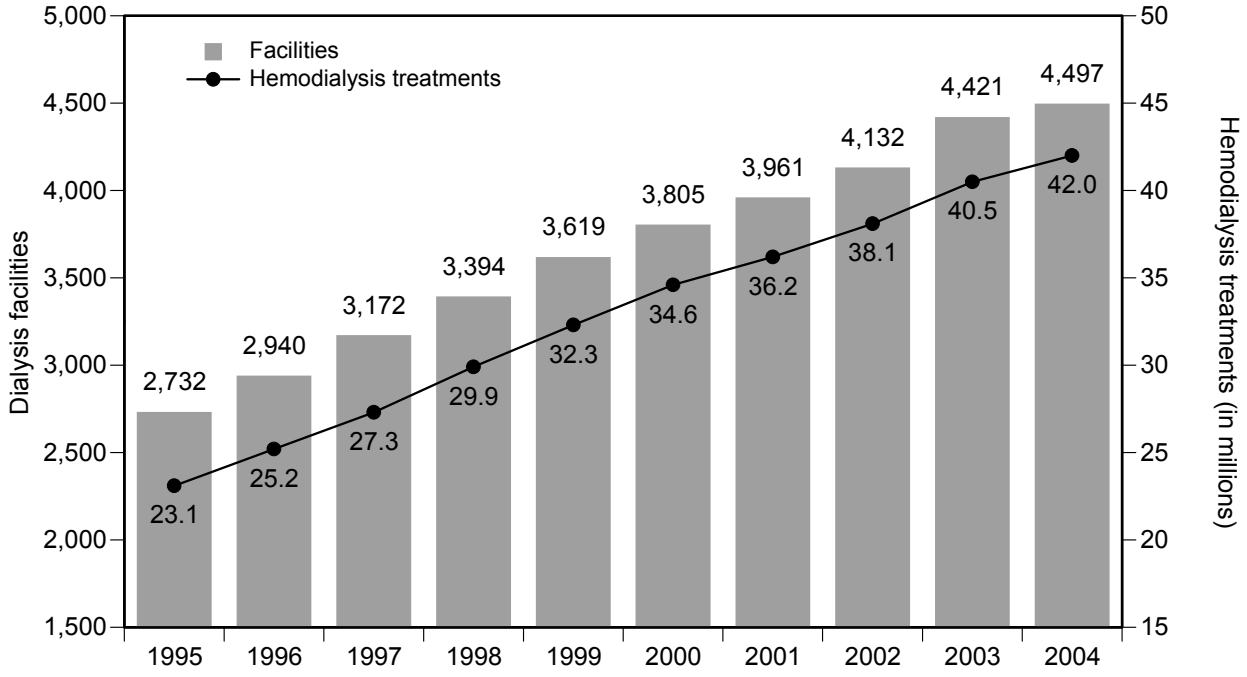
Chart 12-2. Medicare spending for outpatient dialysis services furnished by freestanding dialysis facilities, 1996 and 2004



Source: Compiled by MedPAC from the 1996 and 2004 institutional outpatient files from CMS.

- Between 1996 and 2004, Medicare spending for both dialysis treatments (for which providers are paid a predetermined rate) and for injectable drugs administered during treatments (for which providers are paid on a per unit basis) increased by about 10 percent per year.
- Two factors contributing to spending growth are the increasing size of the dialysis population and the growing use of injectable drugs, such as erythropoietin, iron supplements, and vitamin D analogues.
- The number of dialysis patients increased by 6 percent annually between 1996 and 2004. This growth is linked to a number of factors, including improvements in survival and increases in the number of people with diabetes, a risk factor for end-stage renal disease.
- Between 1996 and 2004, estimated spending for injectable drugs increased by 15 percent annually; in contrast, spending for dialysis increased by 8 percent annually during this time period.

Chart 12-3. Dialysis facilities' capacity increased steadily between 1995 and 2004

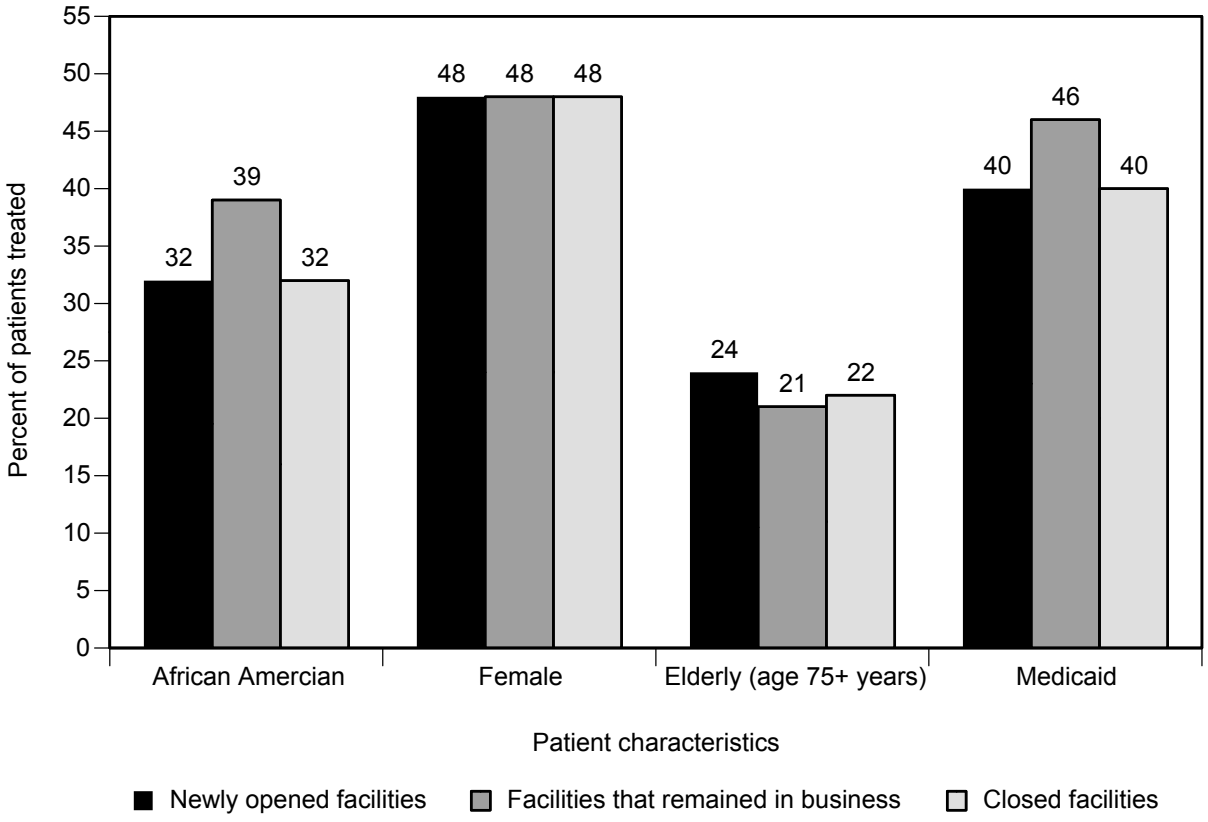


Source: Compiled by MedPAC from the 1993–2004 facility file from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2004, a facility provided about 9,500 treatments per year on average.

- Between 1995 and 2004, the total number of dialysis facilities grew by about 6 percent annually, and the number of hemodialysis treatments grew by 7 percent annually.

Chart 12-4. Characteristics of beneficiaries vary somewhat according to the dialysis facility's business status in 2001 and 2002



Note: The 122 closed facilities are those that were open for business in 2001 but closed in 2002. The 3,752 facilities that remained in business are those that were open for business in 2001 and 2002. The 253 newly opened facilities are those that did not provide dialysis services until 2002. Patients may receive care from more than one facility. A total of 9,296 patients received care at closed facilities; 337,637 received care from facilities that remained in business; and 11,412 received care from facilities newly opened in 2002. Results are weighted by the number of treatments patients received from each facility.

Source: Compiled by MedPAC from the 2005 Renal Management Information System file (the number of dialysis treatments provided to each beneficiary), 2001–2002 denominator files (beneficiaries' demographic characteristics and Medicaid eligibility status), 2000–2003 facility surveys, and 2003–2004 Compare database (facilities' business status and characteristics) from CMS.

- Facilities that stayed in business in both years treated a greater proportion of patients who were African American or dually eligible for Medicaid compared with facilities that closed or were newly opened.
- The characteristics of the patients treated by closed and newly opened facilities were similar—32 percent were African American, nearly half were female, nearly one-quarter were elderly, and 40 percent were dually eligible for Medicaid.
- In 2002, providers' capacity to furnish care increased by 131 facilities and by about 2,000 hemodialysis stations (data not shown).
- These results together suggest that beneficiaries should not be experiencing problems accessing needed care.

Chart 12-5. The ESRD population is growing, and most ESRD patients undergo dialysis

	1994		1998		2003	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	272.3	100%	356.0	100%	453.0	100%
Dialysis	200.4	74	260.4	73	324.8	72
In-center hemodialysis	167.7	62	230.5	65	296.8	66
Home hemodialysis	0.8	<1	1.6	<1	1.3	<1
Peritoneal dialysis	29.5	11	26.8	8	25.9	6
Unknown	2.3	<1	1.4	<1	0.8	<1
Functioning graft and kidney transplants	71.9	26	95.5	27	128.1	28

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with end-stage renal disease (ESRD) require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 6 percent annually between 1994 and 2003.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Hemodialysis use is growing, while use of the two types of dialysis administered in patients' homes—peritoneal dialysis and home hemodialysis—is declining.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. About 40 percent of the kidneys were from living donors and 60 percent were from cadaver donors.
- Medicare is the primary payer for about 80 percent of all dialysis patients and for about half of all kidney transplant and functioning graft patients.

Chart 12-6. Diabetics and the elderly are among the fastest growing segments of the ESRD population

	Percent of total in 2003	Annual percent change 1996–2003
Total (n = 452,957)	100%	5%
Age		
0–19	2	3
20–44	21	2
45–64	43	7
65–74	20	5
75+	16	8
Sex		
Male	55	6
Female	45	5
Race/Ethnicity		
White	61	5
African American	32	5
Native American	1	6
Asian	4	8
Hispanic	13	9
Non-Hispanic	87	5
Underlying cause of ESRD		
Diabetes	36	7
Hypertension	24	5
Glomerulonephritis	16	4
Other causes	23	5

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among end-stage renal disease (ESRD) patients, about 35 percent are over age 65. About 60 percent are white.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 5 percent annually between 1996 and 2003. Among the fastest growing groups of patients are those who are over age 75 and those with diabetes as the cause of kidney failure.

Chart 12-7. Aggregate margins vary by type of freestanding dialysis facility, 2003

Type of facility	Percentage of all treatment	Percentage of payments from dialysis drugs	Aggregate margin
All facilities	100%	41%	2.4%
Urban	84	41	2.7
Rural	16	42	1.4
For profit	90	41	2.7
Nonprofit	10	38	–0.3
Four largest chains	73	42	3.7
Other chains	14	39	–1.1
Nonchain	12	38	–1.9
Furnishes per year:			
≤ 10,000 treatments	27	42	–2.2
> 10,000 treatments	73	41	4.2

Note: Margins include payments and costs for composite rate services and injectable drugs. Margins are adjusted to reflect MedPAC's analysis of audited cost reports, which found that the ratio of allowable to reported cost per treatment for composite rate services is 95.5 percent.

Source: Compiled by MedPAC from the 2001 and 2003 cost reports and the 2003 institutional outpatient file from CMS.

- For 2003, the adjusted aggregate Medicare margin for composite rate services and injectable drugs was 2.4 percent.
- Aggregate margins vary based on a facility's size, affiliation with the four largest chains, and profit status. This finding stems from differences in the cost per treatment; for example, total cost per treatment was 6 percent higher for independent facilities than for facilities affiliated with the four largest chains. In addition, this finding also reflects differences in the proportion of payments facilities receive from composite rate services, which are less profitable than dialysis injectables.
- Aggregate margins for composite rate services and injectable drugs declined from 5.5 percent in 2000 to 2.4 percent in 2003. During this period the composite rate increased twice, by 1.2 percent in 2000 and 2.4 percent in 2001. In addition, providers' cost per treatment for composite rate services spiked between 2000 and 2002. Although providers' cost per treatment for dialysis injectables increased during this period, the difference between payments and costs remained about the same.

Chart 12-8. Use of hospice among Medicare beneficiaries increased from 2000 to 2004

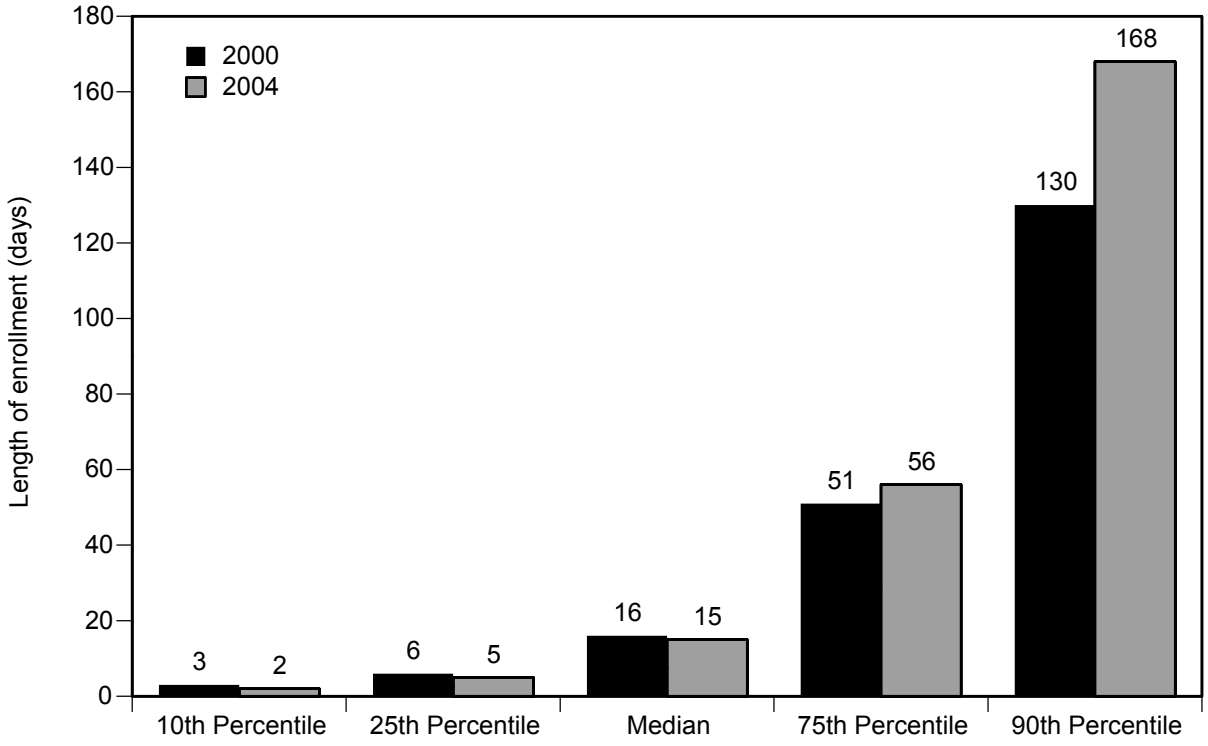
	2000	2004	Percent change 2000–2004
Beneficiaries in hospice	534,261	797,117	49%
Payment (in billions)	$2.9	$6.7	130
Days of care (in millions)	26	52	101
Share of decedents in hospice	22%	31%	N/A

Note: N/A (not available). Data include Puerto Rico.

Source: Share of decedents in hospice from MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS. Beneficiaries, payment, and days of care from Medicare National Summary for HHA, Hospice, SNF, and Outpatient. http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/02_MedicareUtilizationforPartA.asp#TopofPage. Accessed February 13, 2006.

- Medicare spending on hospice increased 130 percent to $6.7 billion between 2000 and 2004. The CMS Office of the Actuary estimates that spending on hospice will grow to $9.8 billion by 2006.
- Medicare's spending on hospice services is projected to increase at an average annual rate of 9 percent per year from 2004 to 2015. This growth outpaces the rates of spending growth for hospital, physician, skilled nursing facility, and home health services.
- Over time, more Medicare beneficiaries have elected to use hospice before they die. The rate of hospice use grew from 22 percent of decedents in 2000 to 31 percent in 2004.
- With the increase in the share of decedents electing hospice before they die, the total number of hospice users has increased. Between 2000 and 2004, the number of hospice users increased almost 50 percent and the total number of covered days doubled during that same period.

Chart 12-9. Long hospice stays are getting longer, but short stays persist

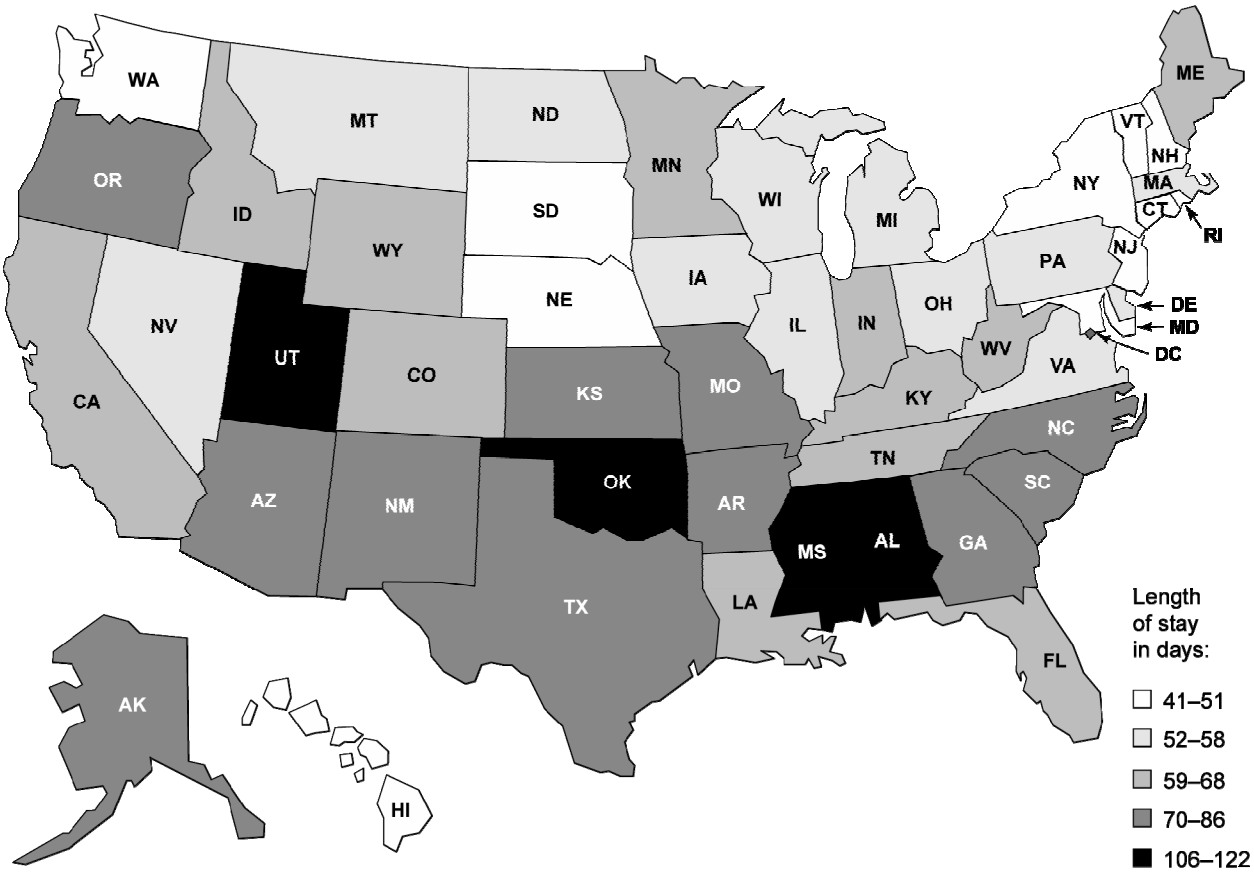


Note: Data are for Medicare beneficiaries in fee-for-service Medicare.

Source: MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS.

- The increase in the number of covered hospice days outpaced the growth in the number of users of hospices. This trend in driven by increasingly longer lengths of enrollment over time for the share of beneficiaries at the upper end of the enrollment distribution.
- Increasingly longer stays at the upper end of the enrollment distribution drove up the mean length of enrollment between 2000 and 2004, but the median length of enrollment remains at about 2 weeks.
- In 2000 and 2004, more than 25 percent of beneficiaries dying in hospice were enrolled for less than a week before their deaths.

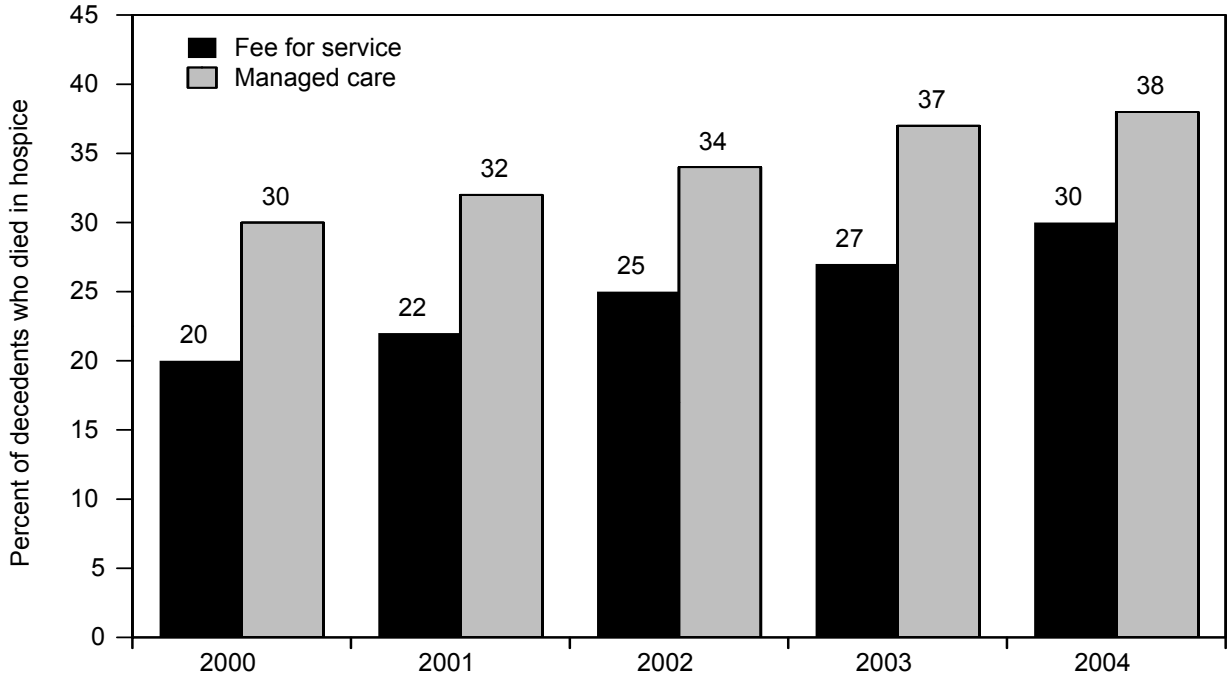
Chart 12-10. Average length of stay in hospice by state, 2004



Source: MedPAC analysis of CMS data from Medicare Hospice Utilization by State, CY 2004. http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/HOSPICE04.pdf. Accessed February 13, 2006.

- Mean lengths of stay in hospice varied widely by state from a low of 41 days in South Dakota to a high of 122 days in Mississippi in 2004.

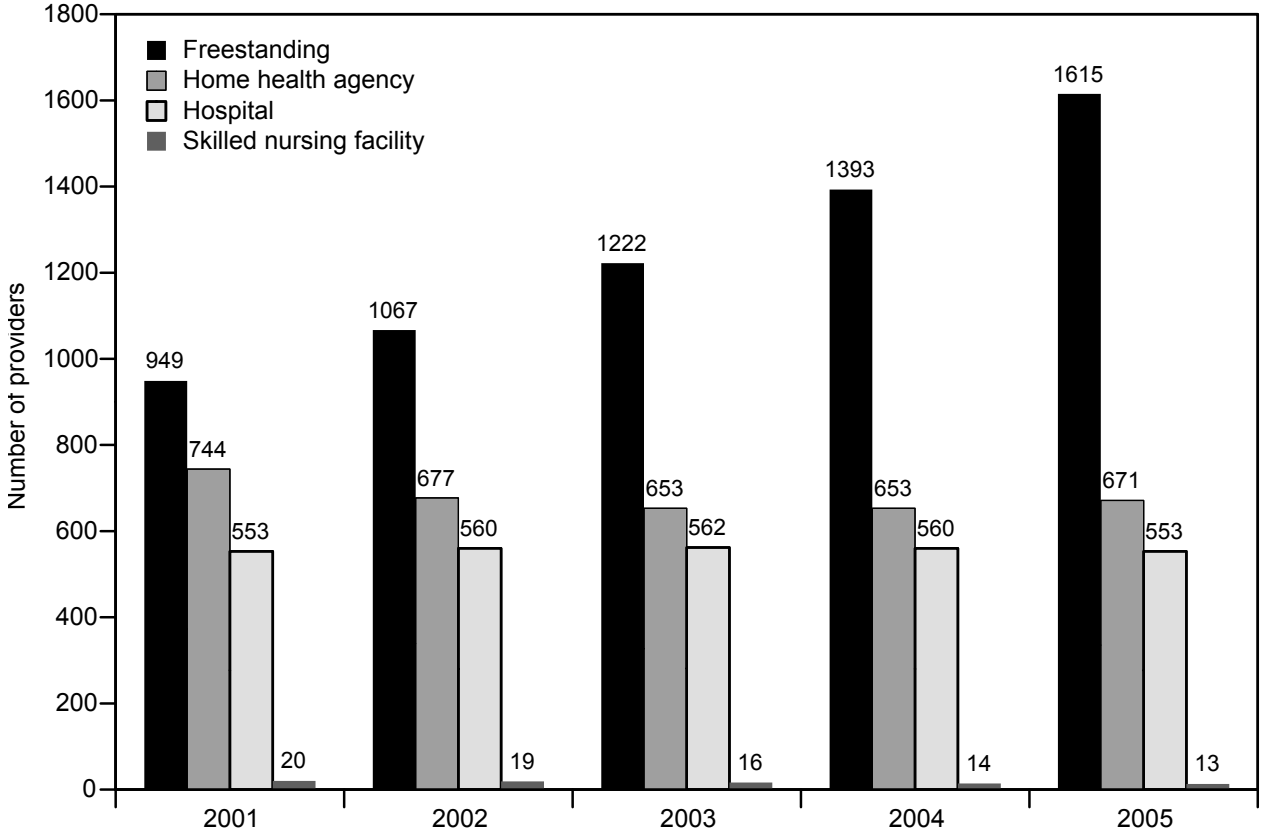
Chart 12-11. Hospice use has grown for all Medicare decedents, but use remains higher among those in managed care



Source: MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS.

- Among beneficiaries who died, those in managed care were more likely to use hospice care than beneficiaries in the fee-for-service program. In 2004, 38 percent of decedents in managed care used hospice, while 30 percent in fee-for-service used hospice.

Chart 12-12. An increase in freestanding agencies fueled growth in the number of hospice providers, 2001–2005



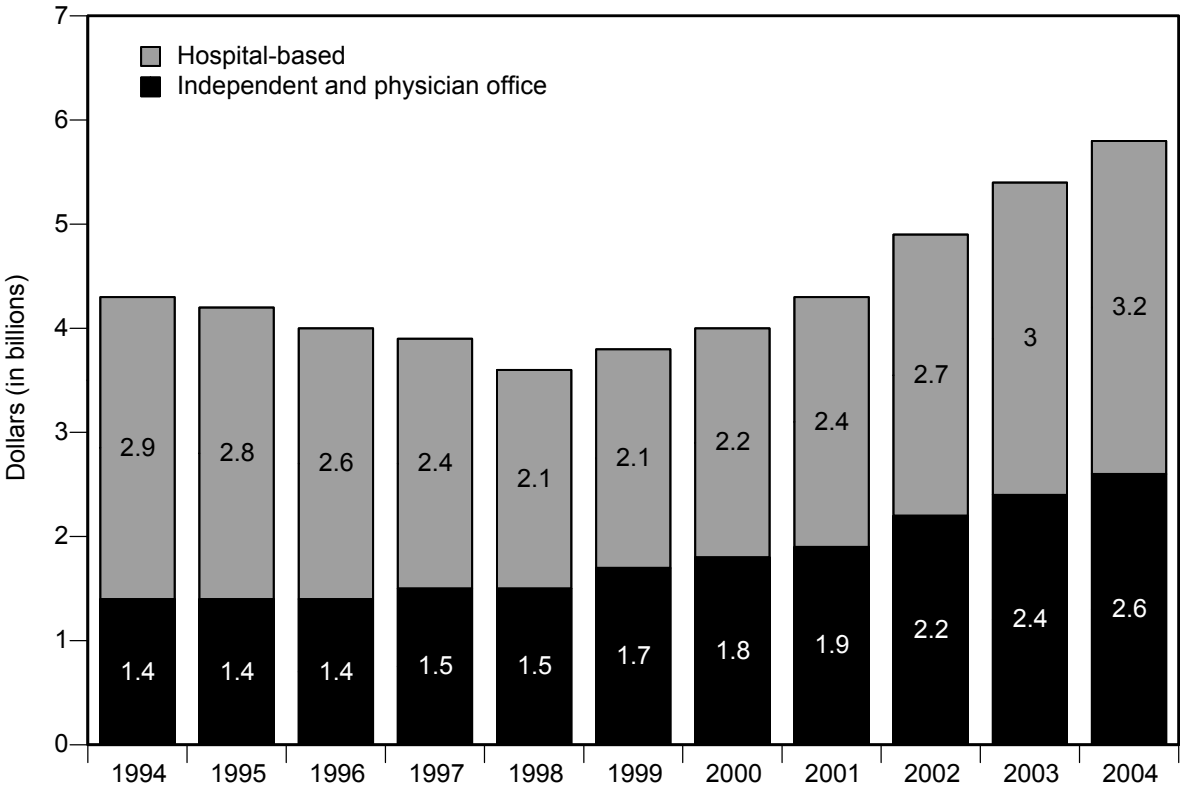
Note: Data for 2001–2005 are as of the end of each calendar year.

Source: MedPAC analysis of unpublished Online Survey, Certification, and Reporting System data from CMS.

- The number of hospice agencies participating in the Medicare program rose 26 percent from 2001 to 2005. This growth is attributable to the growth in freestanding hospice providers, which accounted for 57 percent of hospices in 2005.

- Over time, for-profit hospices have come to take up a larger share of hospice providers (not shown). As of February 2006, 46 percent of hospice providers were for profit, compared to 31 percent in 2001.

Chart 12-13. Medicare spending for clinical laboratory services, in billions, FY 1994–2004



Note: FY (fiscal year). Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services furnished to noninpatients in laboratories owned or operated by hospitals.

Source: CMS, Office of the Actuary.

- Repeated reductions in Medicare's payment rates for clinical laboratory services resulted in declining overall program spending throughout the 1990s, particularly for services furnished in independent and physician office labs. Since 1999, however, growth in volume has caused Medicare expenditures for lab services to climb an average of 9 percent per year.

- In 2004, Medicare payments for clinical laboratory services totaled an estimated $5.8 billion, or 2 percent of total program spending.

Chart 12-14. Hospital and independent laboratories account for most ambulatory test volume

Type of facility	Number of labs	Share of total labs	Share of total test volume	Share of total payments
Physician office labs	104,944	54.5%	17.3%	15.5%
Hospital labs	8,617	4.5	49.3	44.1
Independent labs	5,239	2.7	30.5	37.3
Other	73,683	38.3	3.0	3.1
Total	192,533	100.0	100.0	100.0

Note: Other includes skilled nursing facility labs, home health agency labs, and other labs. Data on number of labs and share of total labs are from 2005. Data on test volume and payments are from 2003. Analysis includes only tests paid under the Medicare clinical laboratory fee schedule; it excludes tests furnished to hospital inpatients and tests furnished to dialysis patients as part of the composite payment bundle.

Source: MedPAC analysis of a 5 percent sample of Medicare claims data and the CMS Clinical Laboratory Improvement Act database.

- The number of labs has grown, on average, about 2 percent per year over the last decade.
- Because some hospitals operate more than one lab, there are more hospital-based laboratories than there are hospitals. Hospital-based labs conduct tests for their inpatients and outpatients and also provide services for nonpatients (referred to as “outreach testing”). Although they account for only 4.5 percent of the nation’s labs, hospital-based laboratories conduct about half of the tests paid under Medicare’s clinical laboratory fee schedule.
- Independent laboratories conduct tests for physicians, hospitals, and other health care providers. Patient samples are frequently taken by other health care providers (in physician offices, hospitals, and other health care settings) and sent to independent labs for analysis, but samples may also be drawn in independent laboratory patient service centers. Although independent labs represent only about 3 percent of all labs nationwide, they furnished 31 percent of tests paid under Medicare’s lab fee schedule in 2003. Independent labs’ share of Medicare payments for tests was even higher (37 percent), consistent with the fact that independent labs are more likely than other labs to provide costly tests.
- Physician office labs represent slightly more than half of all labs, but most (about 80 percent) perform only a few simple types of tests. Thus, physician office labs furnish only 17 percent of the lab services paid under Medicare’s clinical laboratory fee schedule.

Chart 12-15. Highest volume laboratory tests, 2003

Test	Percent of total volume	Percent of total payments	Average annual volume growth, 2001–2003
Complete blood count, automated	8.2%	9.4%	25.0%
Prothrombin time	6.3	3.6	8.3
Comprehensive metabolic panel	5.6	7.4	13.9
Lipid panel	4.7	7.0	11.3
Basic metabolic panel	3.8	4.1	6.9
Assay of thyroid-stimulating hormone	3.1	7.7	11.0
Glycated hemoglobin test	2.3	3.3	13.0
Urinalysis, automated, with scope	1.5	0.7	9.7
Urinalysis, nonautomated, with scope	1.4	0.7	–4.0
Assay of creatinine	1.4	0.5	–2.2
Top 10 tests	38.4	44.5	11.9

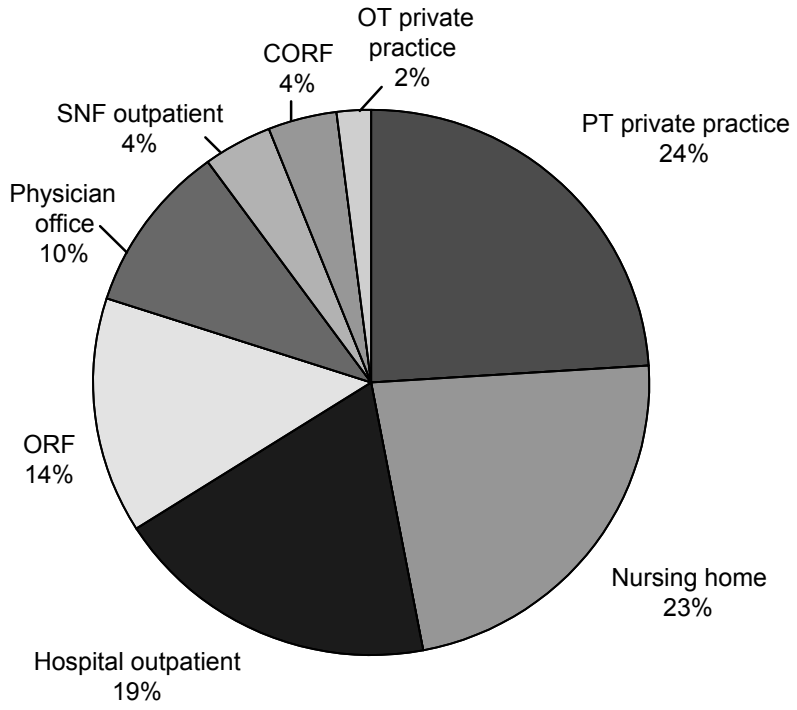
Note: The most frequently provided service on Medicare's clinical laboratory fee schedule is not a laboratory test. Venipuncture, the drawing of blood for a test specimen, accounts for 18 percent of total volume and 6 percent of total payments.

Source: MedPAC analysis of Medicare claims data.

- Although there are more than 1,000 items on Medicare's lab fee schedule, the volume of tests is fairly concentrated, with the top 10 tests accounting for 38 percent of total volume and 45 percent of total payments.

- Five of the highest volume tests—complete blood count (CBC), comprehensive metabolic panel, lipid panel, thyroid stimulating hormone assay, and glycated hemoglobin—grew more than 10 percent between 2001 and 2003, with CBC volume rising at a rate of 25 percent per year. Many of the laboratory tests that are growing rapidly are recommended by clinical guidelines for the treatment of certain chronic conditions. For example, complete blood count tests and metabolic panel tests are quality indicators for congestive heart failure, and the lipid panel and hemoglobin tests are quality indicators for diabetes.

Chart 12-16. Outpatient therapy is furnished by many different entities



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), SNF (skilled nursing facility), CORF (comprehensive outpatient rehabilitation facility), OT (occupational therapist). Based on share of Medicare spending in 2004. PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

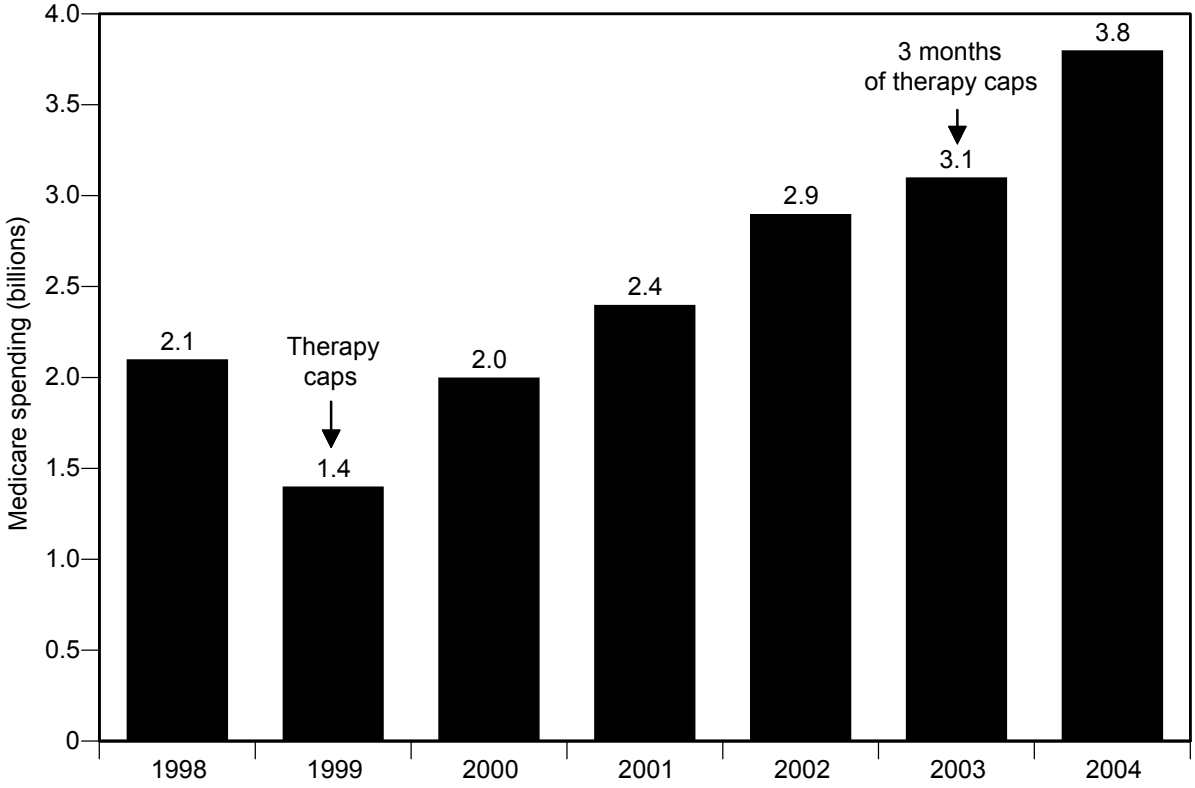
Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 2004.

- Outpatient therapy services are furnished in a variety of settings, both institutional (e.g., nursing homes and hospital outpatient departments) and independent (e.g., therapists' and physicians' offices).

- Services are increasingly provided in independent settings. The share of services furnished in nursing homes and in hospital departments was considerably smaller in 2004 (23 percent and 19 percent, respectively) than in 2002 (30 percent and 24 percent, respectively).

- Services furnished by physical therapists in private practice (which include therapists working for physicians' practices and billing independently) and those provided in nursing homes to long-stay nursing home residents accounted for almost half of outpatient therapy services.

Chart 12-17. Medicare spending on outpatient therapy services has almost doubled since 2000



Note: Therapy caps were in effect for all of 1999 and for three months in 2003.

Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 1998–2004.

- Medicare spending on outpatient therapy services in 2004 was $3.8 billion, up from $2 billion in 2000. This growth was a result of more beneficiaries using therapy services and more services being furnished to each user.

- Spending slowed during 1999, when limits on Medicare payments per beneficiary (the therapy caps) were in place. One therapy cap limited spending per beneficiary for physical therapy services and speech-language pathology services; the other limited spending on occupational therapy services. When first put in place in 1999, each cap was $1,500.

- In January 2006, the $1,500 therapy caps were reinstated. The caps are updated each year for inflation and are currently $1,740. However, as required by the Congress, there is now an exceptions process allowing beneficiaries with high care needs to apply for exemption from the therapy caps.

Chart 12-18. Outpatient therapy users and service have increased since 2000

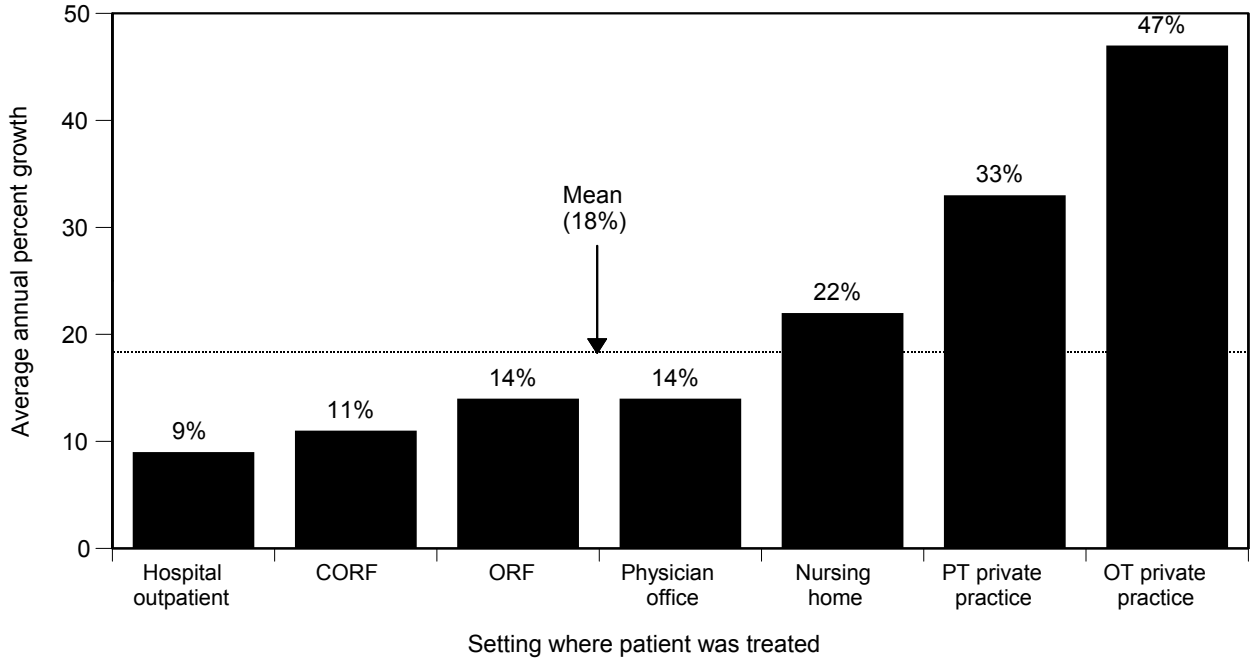
	1998	1999*	2000	2001	2002	2003*	2004	Average annual change 2000–2004
Spending (billions)	$2.1	$1.4	$2.0	$2.5	$3.0	$3.2	$3.9	18%
Users (millions)	3.1	3.0	3.3	3.7	4.0	4.2	4.5	8
Spending per user	$671	$469	$621	$693	$749	$760	$883	9

Note: *Indicates the year in which the therapy caps were in operation (full year in 1999, 3 months in 2003).

Source: MedPAC analysis of the 5 percent file of carrier and fiscal intermediary claims for 1998–2004.

- Medicare spending on outpatient therapy services increased an average 18 percent per year between 2000 and 2004. This rapid growth was the result of both beneficiaries using therapy services and more services being furnished to each user.
- The number of users increased an average of 8 percent per year between 2000 and 2004, much faster than the 1 percent to 2 percent annual growth in the number of beneficiaries.
- Service intensity, as measured by spending per user, increased 9 percent per year during this period. Although fee schedule increases account for some of this increase, the number of units of service billed during this period grew an average of 13 percent per year. Growth in services commonly furnished, not new modalities, drove the increases.

Chart 12-19. Medicare spending on therapists in private practice grew faster than that for other providers, 2000–2004



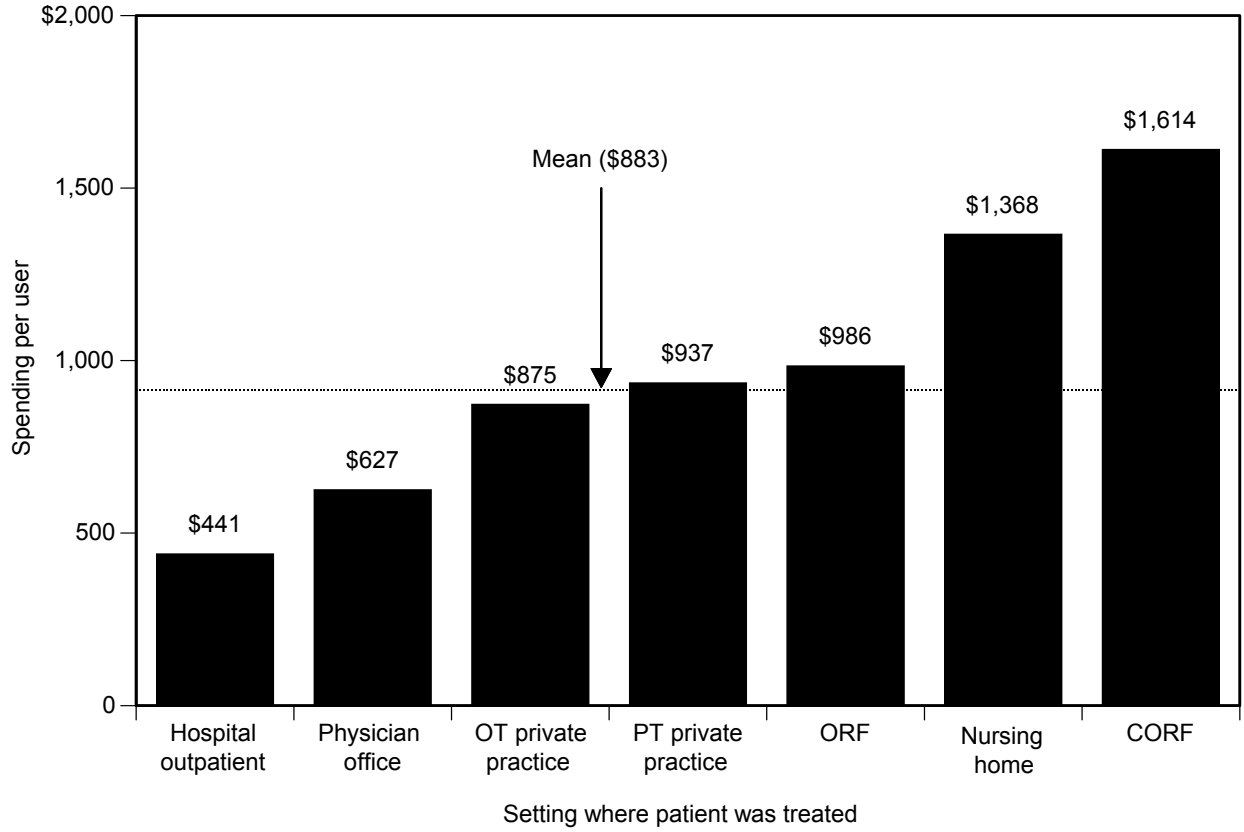
Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- Between 2000 and 2004, spending on outpatient therapy grew an average 18 percent a year, but this number varied considerably by provider setting. Spending in hospital outpatient departments grew the slowest, while therapists in private practice (physical and occupational therapists) grew the fastest.

- The number of therapists in private practice who furnished services to beneficiaries more than doubled between 2000 and 2004. Several factors contributed to this growth, including changes in the way therapists were paid in institutional settings, which encouraged them to establish their own practices, and changes in Medicare rules that allowed licensed therapists to bill directly for services they furnished.

Chart 12-20. Per user spending on outpatient therapy varied threefold across settings, 2004



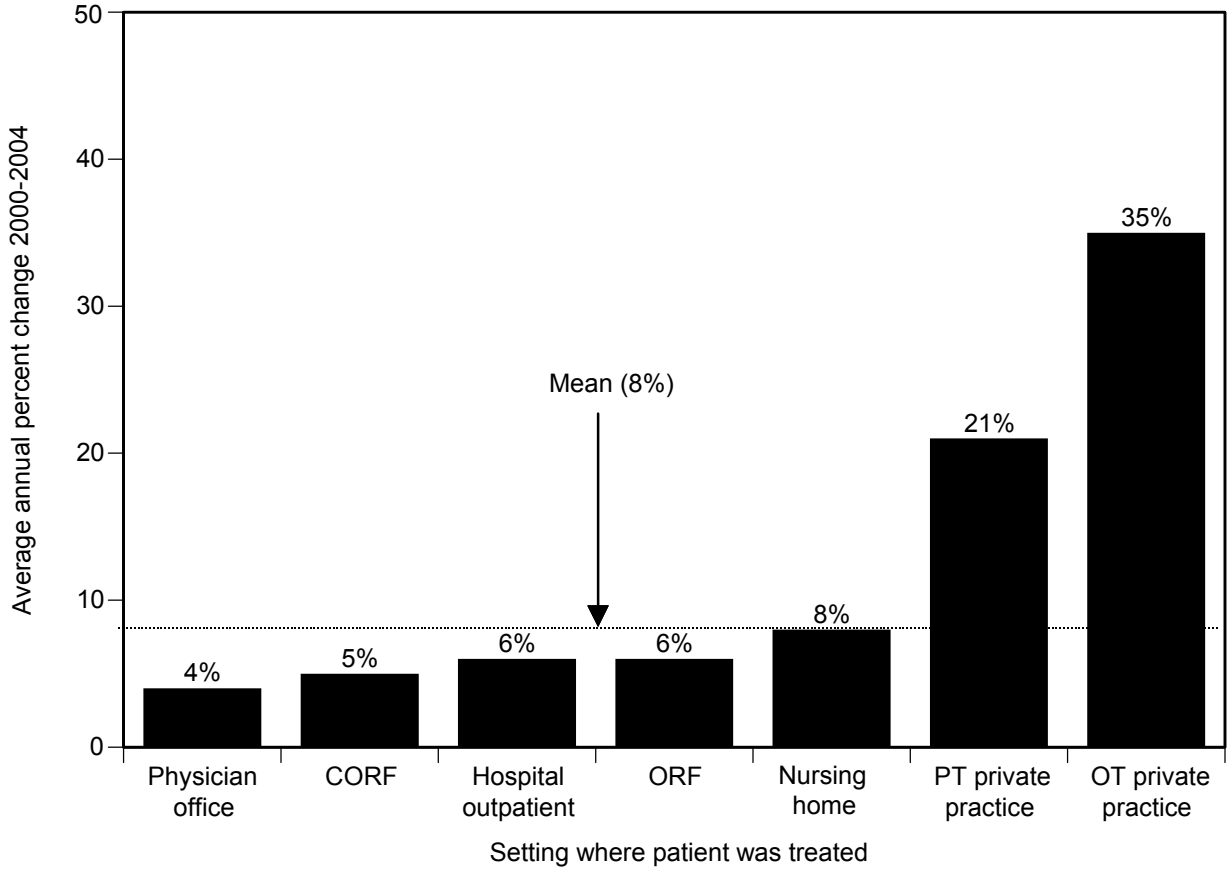
Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- In 2004, Medicare spending on outpatient therapy services averaged $883 per user. However, spending varied considerably by setting. Spending was the lowest in hospital outpatient departments ($441) and the highest in CORFs ($1,614). Because payment rates are the same across settings, differences are attributable to the volume and intensity of services.

- There was a twofold variation across states (data not shown). In states with low per user spending, beneficiaries received a higher share of their therapy in hospital outpatient departments compared with states with high per user spending.

Chart 12-21. Since 2000 the number of outpatient therapy users grew 8 percent a year



Note: CORF (comprehensive outpatient rehabilitation facility), ORF (outpatient rehabilitation facility), PT (physical therapist), OT (occupational therapist). PT private practice and OT private practice include therapists employed by physician groups who bill independently and are not furnishing services incident to physician services.

Source: MedPAC analysis of 5 percent fiscal intermediary and carrier 2000–2004 claims files.

- On average, the number of therapy users grew 8 percent per year between 2000 and 2004. The number of beneficiaries treated in private practice grew much faster than average.

- The number of therapists in private practice who furnished services to beneficiaries more than doubled between 2000 and 2004. This growth reflected many policy changes since the late 1990s that allowed therapists to bill independently and encouraged them to establish their practices as private practices.

Web links. Other services

Dialysis

- More information on Medicare's payment system for outpatient dialysis services can be found in MedPAC's Payment Basics series.
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_dialysis.pdf

- The US Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.
  http://www.usrds.org

- The National Institute of Diabetes & Digestive & Kidney Diseases and the National Kidney Foundation provide health information about kidney disease for consumers.
  http://www.niddk.nih.gov/
  http://www.kidney.org/

- CMS provides specific information about each dialysis facility.
  http://www.medicare.gov/Dialysis/Home.asp

- Chapter 2C of the MedPAC March 2006 Report to the Congress provides information about the financial performance of dialysis facilities.
  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02C.pdf

- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.
  http://www.medpac.gov/publications/congressional_reports/June05_Ch4.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.
  http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004 includes changes in how to pay for services furnished by nephrologists.
  http://www.medpac.gov/publications/other_reports/100603_RevPhysFeeSched_CB_comment.pdf

Hospice

- More information on Medicare's payment system for hospice services can be found in MedPAC's Payment Basics series.
  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_hospice.pdf

- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 3 of MedPAC's June 2006 Report to the Congress, available at http://www.medpac.gov/publications/congressonal_reports/Jun06_ch03.pdf

- Chapter 6 of the MedPAC's June 2004 Report to the Congress reviews trends and policy issues for the Medicare hospice benefit.
  http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf

- The MedPAC May 2002 Report to the Congress: Medicare beneficiaries' access to hospice provides information on beneficiaries' access to hospice care.
  http://www.medpac.gov/publications/congressional_reports/may2002_HospiceAccess.pdf

- Chapter 7 of the MedPAC June 1999 Report to the Congress examines end-of-life care and makes policy recommendations.
  http://www.medpac.gov/publications/congressional_reports/Jun99%20Ch7.pdf

Clinical laboratory

- Information about CMS regulation of clinical laboratories, including the number and type of certified labs in the U.S., can be found on the CMS website.

  http://www.cms.hhs.gov/CLIA

Outpatient therapy

- Chapter 6 of MedPAC's June 2006 Report to the Congress provides information about outpatient therapy services.

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch06.pdf

- A description of the history and impact of the therapy caps can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_Medicare_Basics_OPT.pdf

MEDPAC Medicare Payment Advisory Commission
601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001
(202) 220-3700 • Fax: (202) 220-3759 • www.medpac.gov